

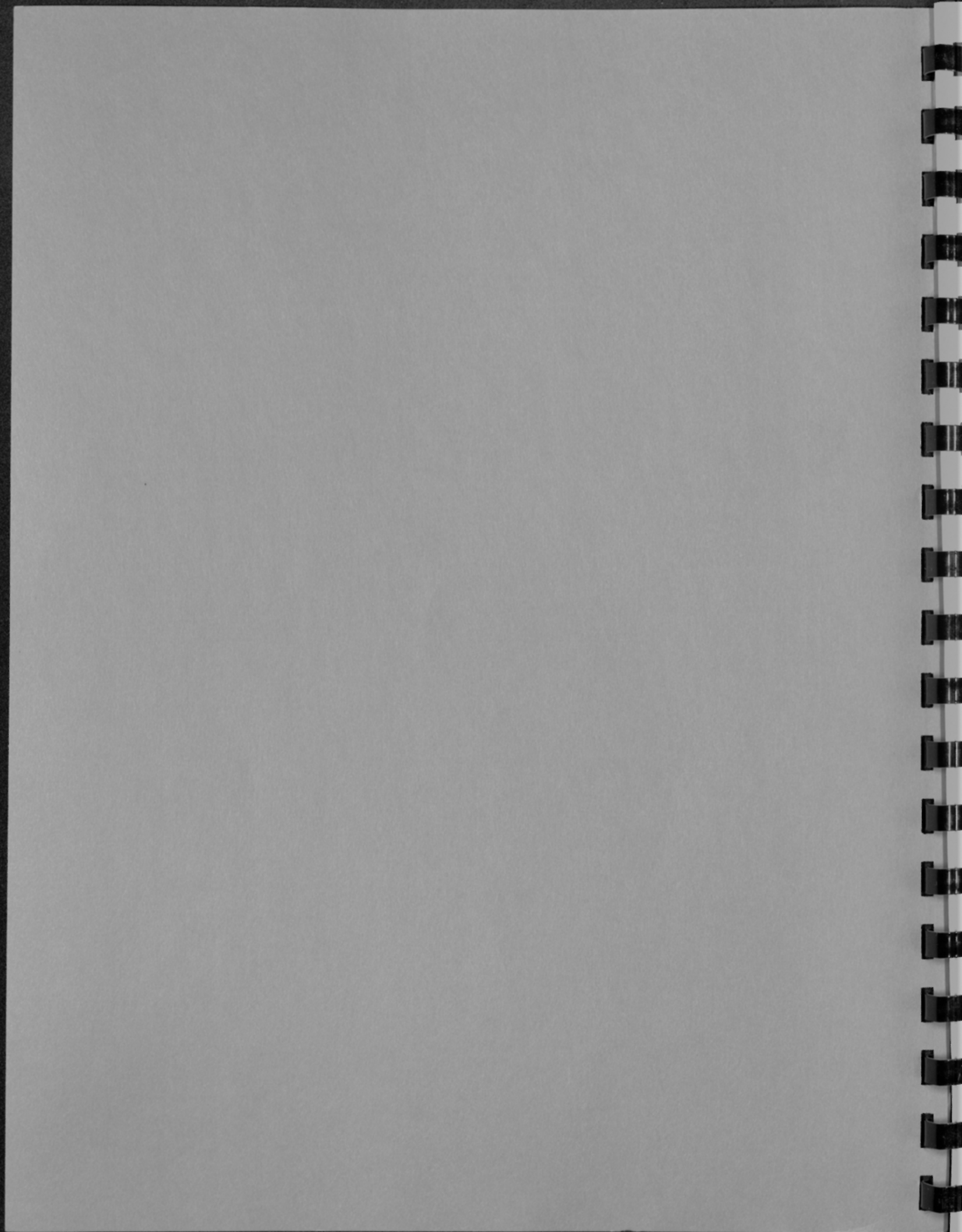
PAIN MANAGEMENT

***A REPORT TO THE FLORIDA LEGISLATURE,
THE AGENCY FOR HEALTH CARE ADMINISTRATION,
AND
THE RESIDENTS OF THE STATE OF FLORIDA***

Florida Pain Management Commission
February 1997

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Florida Pain Management Commission
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FLORIDA PAIN MANAGEMENT COMMISSION

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RECOMMENDATIONS FROM PARTICIPANTS IN THE THREE PUBLIC FORUMS:

1. Include special groups, such as massage therapists (and other therapists), chiropractors, osteopathic physicians and dentists in any pain management strategies.
2. Include special types of pain, including pediatric pain, labor pain and geriatric pain in any pain management strategies.
3. Include the following issues in any strategies to be addressed:
 - a) Use of guidelines for management of pain.
 - b) Use of narcotics for treatment of pain.
 - c) Reimbursement for pain management services.
 - d) Regulation of pain management centers.

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EXECUTIVE SUMMARY

Pain, whether due to trauma, surgery, cancer or other diseases, is often under treated. Unrelieved pain has a harsh and sometimes disastrous impact on the quality of life of people and their families. The National Institutes of Health (NIH) conservatively estimates that 40 million Americans suffer from chronic, debilitating pain. Considering that only 2 percent of these sufferers can be expected to resume their full schedules without effective treatment, pain costs the American economy perhaps \$90 billion a year.

While some progress is being made to improve pain and symptom management, a number of factors continue to interfere with effective pain management. These include the low priority of pain management in our health care system, incomplete integration of current knowledge into medical education and clinical practice, lack of knowledge among consumers about pain management, exaggerated fears of opioid side effects and addiction, and fear of legal consequences when controlled substances are used. Concern about the under treatment of pain has prompted a number of groups, including legislators, state agencies, professional associations, consumer advocacy groups and other concerned health care professionals, to begin working together to bring an awareness of the problems to the public attention and help remove many of the barriers to effective pain management.

The 1994 Florida Legislature provided for a pain management study commission to be administered by the Agency for Health Care Administration. The commission, officially named the Pain Management Commission, held its first meeting in Orlando on January 28, 1995. This organizational meeting set the framework for the formulation of a mission statement, set of objectives and outline of major activities that the Pain Management Commission would undertake. The Commission decided to hold three public forums throughout the state that would provide the opportunity for input through public testimony and completion of a written survey. The results of the forums would be compiled into a report and presented to the legislature. The report would also include a set of recommendations to the Florida Legislature, based on the outcomes of the testimony and survey.

The three forums were held in Tallahassee (April 6, 1995), Orlando (May 18, 1995), and Miami (June 8, 1995). Seventy-seven (77) of the 148 participants presented oral testimony. Speakers included health care providers (52) as well as pain sufferers (22). The results, outlined below, include the legislative recommendations.

RECOMMENDATIONS FROM PARTICIPANTS IN THE THREE PUBLIC FORUMS:

1. Include special groups, such as massage therapists (and other therapists), chiropractors, osteopathic physicians and dentists in any pain management strategies.
2. Include special types of pain, including pediatric pain, labor pain and geriatric pain in any pain management strategies.
3. Include the following issues in any strategies to be addressed:
 - a) Use of guidelines for management of pain,
 - b) Use of narcotics for treatment of pain,
 - c) Reimbursement for pain management services,
 - d) Regulation of pain management centers,

- e) Education of health care providers and pain sufferers,
- f) Collection and use of outcomes data,
- g) Availability of grants funds for pain management data collection and analysis,
- h) Patient lifestyle as a factor in the management of pain,
- i) Certification of pain specialists, and
- j) Multidisciplinary approach to pain management.

Those issues most frequently discussed and considered to be of greatest concern by the participants included:

- 1. Reimbursement for pain treatment,
- 2. Prescribing of narcotics for pain sufferers, and
- 3. Education of physicians and other health care professionals, pain sufferers and the general public about treatment of pain.

RESULTS OF THE PAIN MANAGEMENT SURVEY:

- The 128 survey respondents were primarily over 40 (71.9%) years of age, female (65 female, 50 male with 13 not responding), and white (79.9%). Seventy-four (of the respondents were health care providers, 57 were pain sufferers. Thirteen considered themselves both health care providers and pain sufferers. Ten classified themselves as "other." Health care providers included nurses (33.8%), medical doctors (23.0%), therapists (21.6%), chiropractors (6.8%), psychologists (4.0%), alternative specialists (4.0%), and other classifications (6.8%).
- Most (68.4%) of the pain sufferers described their type pain as chronic, with 73.7% indicating their pain interfered with activities of daily living (such as dressing, eating, walking, sitting, standing, and shopping). Tylenol, Aspirin and Advil were the most common over-the-counter drugs used to help relieve pain, with 49.1% (28) also reporting use of narcotics and 45.6% (26) using muscle relaxants. The leading treatment for pain was physical therapy (66.7%), followed by massage therapy (52.6%) and counseling and pain treatment facilities (40.4% each). Two respondents reported surgery and two reported TENS for treatment.
- The top five (5) reasons health care providers reported terminating pain treatment other than the patient no longer needed such treatment are ranked below:
 - 1. Third party intervention problems - insurance (or Medicare/Medicaid) refused to reimburse or canceled reimbursement,
 - 2. Failure of the patient to give full effort to comply with pain treatment program,
 - 3. Complicating medical or psychological problems became barriers,
 - 4. Physician problems - primary care physician refused to order appropriate medicine and/or removed patient from the program, and
 - 5. Patient could not afford to pay and had no insurance coverage.
- Pain sufferers who believed their treatment had been inadequate ranked their reasons, as summarized below:
 - 1. Lack of knowledge of resources available to receive proper treatment of pain,
 - 2. Insensitivity or lack of concern for my pain by my health care provider(s),
 - 3. Reluctance of my physician to prescribe adequate drugs to treat my pain due to fears of reprimand,
 - 4. Deficiencies within state and/or federal laws regarding adequate treatment of pain, and
 - 5. Lack of appropriate health care providers/facilities to properly treat my pain in my community.

RECOMMENDATIONS TO THE FLORIDA LEGISLATURE:

The Pain Management Commission urges the Florida Legislature to endorse the recommendations listed below and, in cooperation with members of the Commission and other medical professionals, (1) actively seek the appropriate legislative action for recommendations requiring statutory revision, and (2) actively engage in dialogue among federal officials and appropriate statewide boards and agencies to promulgate enactment of rules and laws for recommendations requiring joint state and federal approval.

The Pain Management Commission recommends the following:

1. Continue funding and recognition of the Pain Management Commission as a voluntary resource to the state of Florida with regard to pain management, which periodically may be called upon in an advisory or educational capacity to assist policymakers, health care professionals and the general public.
2. All citizens of the state of Florida have the right of access to treatment for relief of pain.
3. Recognize chronic pain as a legitimate condition with appropriate coding for services.
4. Provide more flexibility to physicians when prescribing or treating patients for pain.
5. Provide for a centralized statewide registry of pain management centers that would include a description of the services provided by each center.
6. Provide for and encourage participation in pain management educational programs for physicians, other health care providers, and pain sufferers and their families.
7. Provide for a clearinghouse on pain management information, including patient information, professional training programs, pain management guidelines, and research-based outcomes.
8. Provide for pain management research, development of a statewide data base of outcomes data, and technology to access other national databases, such as those available through the internet or other major networks.
9. Promote the teaching of pain management as an integral component of the curricula of schools for health care professionals, including, but not limited to, medical, osteopathy, chiropractic, nursing, pharmacy, and dental schools.

INTRODUCTION

Most people experience pain at some time in their lives. Such pain is often described as *acute pain*, associated with injury, illness, or surgery; or *chronic pain*, due to cancer, degenerative diseases and other conditions. Unrelieved pain impedes recovery from surgery, injury, or illness; interferes with physical function and productivity; destroys the quality of life; and increases the use of health care services, thereby increasing the cost of health care. Chronic pain, for example, affects nearly one-third of the U.S. population at an estimated cost of \$80 billion. Approximately 34 million American adults see their physicians at least once a year for chronic pain that affects their quality of life.

There is wide variation in the methods used to manage pain, ranging from no set strategy to sets of comprehensive guidelines for specific types of pain management. Although there are a number of effective treatments available to relieve pain, many patients do not receive such treatment. Complicating the strategies are legal and moral issues which result in general under treatment of pain. Research indicates pain is more likely to be under treated if the patient is a minority, female, elderly, or a child.

Many believe better pain management would overcome the widespread fear of an agonizing, undignified death. Methods to keep most terminally ill people awake and moderately pain-free are available, they just beginning practiced by only a few physicians. One study found that only half of the patients in the nation's best cancer treatment centers were getting adequate pain management.

Concern about the under treatment of pain has prompted a number of diverse groups to unite in the past few years. Legislators, state agencies, professional associations, consumer advocacy groups and other concerned health care professionals have been working together to bring an awareness of the problems to public attention and remove many of the impediments to effective pain management. In Florida, the 1994 Legislature provided for a pain management study commission to be administered by the Agency for Health Care Administration.

This report of the Pain Management Commission and AHCA presents a brief overview of the background and issues of pain management and provides summaries of a series of three public pain management forums held in Tallahassee, Orlando, and Miami during the months of April, May and June, 1995, respectively. A final section provides recommendations of the Commission to the Legislature.

INTRODUCTION

Most people experience pain at some time in their lives. Such pain is often described as acute pain, associated with injury, illness, or surgery, or chronic pain, due to cancer, degenerative diseases and other conditions. Unrelieved pain impedes recovery from surgery, injury, or illness; interferes with physical function and productivity; decreases the quality of life; and increases the size of health care services, thereby increasing the cost of health care. Chronic pain, for example, affects nearly one-third of the U.S. population at an estimated cost of \$80 billion. Approximately 34 million American adults see their physicians at least once a year for chronic pain that affects their quality of life.

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Many believe better pain management would overcome the widespread fear of an escalating, uncontrolled drug. Methods to keep most patients in pain awake and moderately pain free are available, they just require practice by only a few physicians. One study found that only half of the people in the nation's best cancer treatment centers were getting adequate pain management.

Concern about the under-treatment of pain has prompted a number of diverse groups to unite in the past few years. Legislators, state agencies, professional associations, consumer advocacy groups and other concerned health care professionals have been working together to bring about changes in the practice to public attention and involvement of the public. In 1994, the 103rd Congress passed legislation providing for a permanent, nonpartisan commission to be administered by the Agency for Health Care Administration.

This report, the Pain Management Commission and AHCJA presents a brief overview of the progress we have made in pain management and provides a summary of a series of three public hearings held in 1994. The first hearing was held in Washington, D.C. on May 11, 1994. The second hearing was held in St. Louis, Missouri on May 12, 1994. The third hearing was held in San Francisco, California on May 13, 1994. A final section provides recommendations of the Commission for the legislation.

BACKGROUND

Recognition of pain management as a separate medical component, deserving recognition and credibility, has been difficult to "sell" in the average medical setting. Pain management, obviously, is a multidisciplinary field that can arguably be a part of management of patients in general, since most of them will experience pain at some point in their treatment regimens. Insurers, for example, that may not provide for pain management specifically, maintain that pain management is already included in the general care of patients.

Pain management proponents, however, maintain that too many patients are needlessly suffering without specific strategies for the treatment of their pain. Through organization and determination to try to improve the quality of life for sufferers of pain, progress is being made to bring the issues and the impediments to effective pain management to the awareness of legislators, health care providers and the general public. Federal efforts and some state legislatures and agencies are beginning to produce guidelines, laws and policies that provide assistance to health providers and remove some of the impediments to successful pain management.

Definitions. *Pain* is an unpleasant sensory and emotional experience rising from actual or potential tissue damage or described in terms of such damage. Pain is generally described as acute or chronic. *Acute pain* is characterized by sudden onset, having sharp rise and lasting for a relatively short time. Acute pain management generally addresses pain associated with surgery, medical procedures, or trauma. *Chronic pain* is marked by long duration or frequent recurrence over a long period of time, often by slowly progressing seriousness. Chronic pain management is more complex and may involve mental or emotional considerations as well as physical treatment. Chronic pain patients often have degenerative diseases or permanent injuries that dramatically impact the quality of their lives. Although *cancer pain* is a special type of chronic pain, because of its uniqueness, it is sometimes treated as a third type of pain.

Intractable pain, another special area, generally refers to a pain state in which the cause cannot be removed or otherwise treated and no relief or cure has been found after reasonable efforts. It may also include pain due to cancer as well as to other chronic diseases. Intractable pain treatment policy refers to laws, regulations, or other government-issued policies and guidelines that address the legitimacy of the medical use of opioid analgesics to treat patients with intractable pain.

Treatment. As previously noted, treatment varies widely among health care providers. Many of the techniques are conventional, some are controversial. Primary treatment modalities generally include medication management; musculo-skeletal manipulation; physical, occupational, and massage therapy; acupuncture, behavioral, psychotherapy, psychiatric medicine, educational and other therapies; and vocational and disability management. Other treatments may include nerve blocks and trigger point injections, or even more invasive techniques such as surgery, implantable spinal devices, continuous infusion devices and/or brain stimulation.

Although many successful treatment modalities are available, the degree of their use and the effectiveness will vary among health care providers and patients. A number of pain

assessment instruments have now been developed to assist in creating an appropriate pain management program for patients.

Much of the treatment for pain is prescribed by the patient's general practitioner or primary care provider. Patients, either by general habit or requirements of their insurance companies, initially seek treatment from these individuals. The responsibility for assessing pain and prescribing appropriate treatment, therefore, often falls upon primary care providers who have had little training, if any, in pain management. Referrals to other specialists or pain treatment centers would only be recommended if the primary care provider determined such action was a necessary part of the patient's treatment regimen and if such referral would be covered by the patient's insurance or workers' compensation plan. It is, therefore, important to pain management proponents that (1) all medical professionals and insurers become educated with respect to treatment of patients suffering from acute or chronic pain, and (2) barriers to appropriate management of pain, especially for those with intractable pain, be removed.

ISSUES AFFECTING SUCCESSFUL PAIN MANAGEMENT

Professionals in the field of pain management recognize that their treatment strategies sometimes are in conflict with the conventional methods of managing patients. Some treatment methods are controversial, and some are not validated scientifically. Other methods, once controversial, have now gained acceptance, but there remains skepticism. Many health care providers are reluctant to change current practices until better proven methods are well established, while others are resistant due to lack of education. For some health care providers, reluctance is primarily the result of too many problems associated with the proper management of pain in patients. A few of the most frequently cited barriers to pain management are discussed below.

Fear of Addiction

Both patients and physicians are concerned about addiction. Many health professionals overestimate the prevalence of dependence and addiction in their patients. Physicians are afraid of addicting their patients and, therefore, they are concerned about using potent opiates. Patients are afraid of becoming addicted to medications. The underlying cause of these fears appears to be a lack of education. Many physicians under-dose both terminally ill patients who are in a lot of pain, and others with acute or chronic pain. Similarly, problems regarding the proper intervals for dosages and proper monitoring to provide alternatives when a particular medication is no longer effective are also part of the controversy.

Coverage/Reimbursement

According to a Louis Harris survey, sponsored by the National Pain Society, two-thirds of patients with mild to moderate chronic pain are covered by health insurance. However, fewer than 17% had plans that fully reimbursed them for medication expenses and over 13% had insurance that did not reimburse expenses for chronic pain medication. Generally, *Medicare* does not cover outpatient prescription drugs. If, however, those patients are admitted to an inpatient facility, such costs are covered. This can result in the admission of elderly patients to the hospital for reimbursement reasons rather than medical reasons. *Hospices* provide palliative care and pain management for people who are dying. By law they must provide quality care even if the cost exceeds per diem reimbursements. Rising analgesic medication costs may affect hospice budgets, limit some services, and lead to further screening of admissions. *Medicaid* is funded by both the federal

Physician Accountability

government and the states. It is the primary public insurance program for low-income families and for people who are blind, disabled, or members of families with dependent children. Approximately one-fourth of state Medicaid programs place restrictions on medications. Restrictions on prescription drugs raise the risk of elderly patients' going to nursing homes.

Regulation

According to a survey done by the Sacramento-El Dorado Medical Society in 1992, 69% of physicians said that they were more conservative in prescribing certain agents as far as dosage, choice of agent, and refills because of the potential for disciplinary action.

Regulatory constraints hinder physician prescribing habits, especially in the regulation of quantity and restriction of refills. Governments, in trying to be very rigid in their control in order to fight drug abuse, have not made allowances for the people that need these drugs for chronic or terminal pain. Many doctors find it frightening to see monthly reviews of suspended licenses that include many abuses of scheduled drugs.

FEDERAL REGULATIONS AND GUIDELINES

As a general principle, the federal government does not regulate medical practice as this is a function of the states. However, through the work of various agencies and some policy statements, there is some federal involvement. In 1974 Congress adopted a law to prohibit physicians from prescribing opioids to detoxify or maintain opioid addiction (unless they are operating as part of a separately registered narcotic treatment program). Subsequently, to clarify the critical distinctions between the treatment of opioid addiction and the use of opioids to treat pain, the Drug Enforcement Administration (DEA) issued a resolution in 1974 stating that the law was not intended to interfere with physicians who used opioids to treat intractable pain. The DEA has reiterated and communicated this policy to U.S. physicians through its Physician's Manual (1990) and Pharmacist's Manual (1986).

Pain management guidelines have also been encouraged through federal efforts. Of the fifteen practice guidelines published by the U.S. Department of Health and Human Services, Agency for Health Care Policy and Research (AHCPR) through December, 1994, two address pain management: acute pain management and cancer pain. A third set of guidelines, dealing with acute low back problems, includes recommendations for treatment of acute low back pain.

POLICIES IN OTHER STATES

State regulations, particularly, relating to physicians' prescribing, are sometimes more restrictive than the federal regulations. A physician's prescribing of controlled substances may be reviewed by a number of agencies. Typically, these agencies want to identify physicians who are prescribing outside of legitimate medical practice. Physicians have been investigated and prosecuted for prescribing opioids for chronic pain. Although states are working on adjustments to laws encouraging these actions, several states continue to have restrictions. States restricting dosages include Missouri, New Hampshire, New Jersey, New York, Rhode Island, South Carolina, Utah and Wisconsin. Over the last several years some legislatures have begun to adopt laws to affirm the use of controlled substances for intractable pain. The chart provides a brief overview of state activities affecting pain management, including intractable pain.

California	<p>In 1990, California became the second state to adopt an intractable pain treatment act. It requires evaluation of the patient by a specialist in addition to the physician. Other legislation required examination of alternatives to the triplicate prescription program, distribution of information on pain management and the California intractable pain treatment policy to all physicians by the medical board, and a medical board survey of state medical school's curricula on pain management.</p> <p>In 1994, the governor sponsored a Summit on Effective Pain Management: Removing Impediments to Appropriate Prescribing to prepare a strategy for a statewide effort to improve pain management. The licensing and disciplinary boards for medicine, pharmacy, and nursing developed positive guidelines for the appropriate use of opioids in intractable pain. The American Pain Society Board of Directors endorsed the medical board's guidelines.</p>
Colorado	In 1992 the legislature adopted an intractable pain treatment policy as part of its controlled substances act. CO's approach is similar to that used in WA.
Hawaii	Legislation has considered legislation that amends the statutes by adding a new section designated to provide relief of severe intractable pain. Provisions would allow use of controlled substances in Schedules II through V for the purpose of relieving severe intractable pain.
New Jersey	NJ has a regulation on intractable pain treatment that mirrors the federal intractable pain regulation, in part. There are limiting conditions on the boundaries of intractable pain treatment. Thus, a NJ physician who prescribes opioids for intractable pain should document compliance with the additional conditions in the patient's chart.
Texas	<p>The nation's first intractable pain treatment act was approved by the legislature in 1989. The legislation authorizes physicians to use controlled substances (but not opioids) for treatment of intractable pain, prohibits health care facilities from restricting the use of such drugs for intractable pain, and prohibits the Texas State Board of Medical Examiners from disciplining a physician for using such drugs in the legitimate treatment of tractable pain. There are also exclusions, such as not protecting the physician if the pain patient is also being treated for chemical dependency or when the physician should have known that the patient was using drugs in a nontherapeutic manner.</p> <p>The Texas State Board of Medical Examiners issued a policy statement endorsing the federal intractable pain regulation and the intractable pain treatment act and stated that the board would use treatment outcome and not quantity or duration of prescribing as a standard for evaluating cases against doctors.</p>
Virginia	In 1988, VA enacted a law allowing physicians to prescribe heroin for treatment of terminally ill cancer patients (despite the fact that legislation at the federal level has failed to pass allowing the availability of heroin). The same year, the VA legislature adopted an additional measure to allow prescription of pain medications in excess of recommended dosage for patients with intractable pain.
Washington	Following opposition from physicians regarding the position of the WA State Medical Disciplinary Board, in 1993 the state legislature enacted a statute that borrowed a provision from a recently developed model for state drug laws developed by medical and legal experts. The provision included a statement that medical treatment included dispensing or administering a narcotic drug for pain, including intractable pain.

Beyond the efforts of state legislatures, a number of other important initiatives relating to pain management have been established. One such effort is *cancer pain initiatives*. The Wisconsin Cancer Pain Initiative was formally organized in December 1986. Because of its pioneering

efforts, Wisconsin has been designated a demonstration state by the World Health Organization (WHO). Approximately 43 other states have established cancer initiatives. Among them are Florida (see next section), Arkansas, Indiana, Texas, Michigan, New York, Ohio, Pennsylvania, Washington, Minnesota, Massachusetts, Missouri, Hawaii, West Virginia, New Mexico and Vermont.

FLORIDA'S PAIN MANAGEMENT ACTIVITIES

The 1994 Florida Legislature approved an intractable pain treatment provision. The legislation required a licensed and qualified physician to diagnose intractable pain and permitted the use of controlled substances in Schedules II-V, not only opioids, to treat a person with intractable pain, provided the physician conforms to a standard of care that would be recognized by reasonably prudent physicians under similar conditions and circumstances. The pain provision also recognizes that the state does not condone mercy killing or euthanasia and bans the use of intractable pain treatment for such a purpose.

The legislature, during its 1994 session, also provided for a pain management study commission. The Pain Management Commission met in early 1995 and defined its mission and objectives. In order to gather input from the public regarding formulation of policy for pain management, it was decided that a series of three public forums would be held throughout the state. The information gathered, both through public testimony and survey, would be used to prepare a report with recommendations to the Florida legislature.

Pursuant to the legislature's interest in pain management, the Florida Medical Association's Ad Hoc Committee on Practice Parameters requested AHCA to endorse AHCPR's guidelines on pain management. The following guidelines relating to pain management have been officially endorsed through notice in the Florida Administrative Weekly:

1. Acute Pain Management: Operative or Medical Procedures and Trauma — Clinical Practice Guideline.
2. Acute Pain Management in Adults: Operative Procedures — Quick Reference Guide.
3. Acute Pain Management in Infants, Children, and Adolescents: Operative and Medical Procedures — Quick Reference Guide.
4. Pain Control After Surgery — A Patient's Guide.
5. Management of Cancer Pain — Clinical Practice Guideline, Quick Reference Guide, Patient's Guide.

Another practice guideline which relates to pain management, *Universe of Florida Patients with Low Back Pain or Injury*, was produced in consultation with the Agency for Health Care Administration's Medical/Surgical Neuro-Musculo-Skeletal Guideline Committee and its Neurological Surgery Subcommittee and endorsed by AHCA on October 6, 1995. This guideline compliments the previously endorsed AHCPR guideline, *Acute Low Back Problems in Adults*.

Florida also has established a cancer pain initiative. The Florida Cancer Pain Initiative held its statewide organizational meeting on October 28, 1994, where the mission and objectives were established. A 12-member steering committee directs activities. The group is actively involved in education and increasing public awareness of the barriers to optimal cancer pain

management. Regional councils have been established to enhance coordination and plan activities and projects which are needed to carry out the mission and accomplish the goals of the initiative. A newsletter, published quarterly, keeps members informed of various activities pertinent to cancer pain management.

PAIN MANAGEMENT FORUMS

As previously noted, the Pain Management Commission held three public forums during the spring of 1995. The first forum was held in Tallahassee on April 6th, the second, in Orlando on May 18th, and the final forum was held in Miami on June 8th. The forums were widely publicized. In addition to publication in the *Florida Administrative Weekly* prior to each forum and statewide press releases, hundreds of flyers were sent to health care providers, members of the legislature, and advocacy groups about the state by AHCA staff members. The local health councils in each area hosting a forum also sent hundreds of flyers to their network of health care professionals and advocates. Members of the Commission also distributed flyers to their patients and colleagues. The *Miami Herald* carried a special article about pain management and the forum in the Miami area. Members of the press were in attendance at the Tallahassee and Miami meetings. A total of 148 persons attended the three public forums, in addition to Commission members, AHCA staff members and assisting staff of the local health councils.

PUBLIC TESTIMONY

Seventy-seven of the 148 participants presented oral testimony. Most of the speakers (52) were health care providers. Twenty-five were pain sufferers, 22 of whom were from the Miami area. However, several health care providers speaking at the Orlando forum indicated they were also pain sufferers. Most of the speakers were from the medical community, primarily physicians. Other speakers represented chiropractic, massage therapy, health psychology, health education and hospice. Testimonies tended to focus on three general areas: (1) health practitioners that the speakers believed should be recognized and included in any formal recommendations relevant to pain management, (2) special types of pain that speakers thought should be recognized, and (3) issues the speakers believed should be addressed by the Commission. *As the recommendations, which are summarized below, are reviewed, it is important to remember they reflect the opinions expressed by the speakers in attendance; not necessarily the opinions of the Pain Management commission.*

Recommendation # 1: Include the following special groups in any pain management strategies:

- Massage therapists (and other therapists)
- Chiropractors
- Osteopathic Physicians
- Dentists

Recommendation # 2: Include the following special types of pain in any pain management strategies:

- Pediatric pain
- Labor pain
- Geriatric pain

Recommendation # 3: The following issues should be included in areas to be addressed by the Commission:

- ✱ **Guidelines for Pain Management.** Many supported the concept of guidelines. However, there did not appear to be universal agreement on the types of guidelines that would best serve the purposes of health practitioners in the area of pain management. Such issues as the degree of specificity of the guidelines and the involvement of government seemed to be especially controversial.
- ✱ **Narcotics.** A number of physicians expressed concerns about the current laws monitoring physicians' prescriptions for their chronic pain patients. There was general agreement that a number of alternatives to narcotics are available for chronic pain, but there are a few patients for whom nothing else can be done to relieve their pain. The issues involve both federal and state guidelines for prescriptions for certain types of patients, including those covered by Medicare and Medicaid. For example, current laws indicate that addicted patients should be detoxified or withdrawn in addiction facilities. Thus, these patients are often not maintained in treatment because of fear of licensure censure within the federal arena. There was general agreement that physicians, who choose to, may prescribe narcotics for their terminally ill cancer patients without too much concern. Hospice workers, however, noted problems with some physicians who still seem reluctant to prescribe appropriately for the terminally ill.
- ✱ **Reimbursement.** This seems to be a major issue among most health care providers. Although the subjects varied, reimbursement problems emerged in many of the testimonies. Again, federal and state reimbursement guidelines are involved. Reimbursement in pain management centers and nursing homes is especially troublesome. Problems involve private insurers, including fee-for-service and managed care, as well as Medicare, Medicaid and Workers' Compensation.
- ✱ **Regulation of Pain Management Centers.** Thoughts were expressed that pain management centers should be recognized and come under some type of regulation and/or accreditation. Apparently, the only existing accreditation currently available to these centers is through other accrediting organizations, such as the Commission on Accreditation of Rehabilitation Facilities (CARF) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Accreditation would only apply to those centers with facilities and programs specific to these organizations. Testimony and comments by commission members revealed wide differences among pain management centers. It was believed that there should be common definitions of terms, such as "multidisciplinary" and some system for determining the types of services existing (or that should exist) in the various centers. Some physicians noted that they had no idea which centers, if any, might meet the needs of their patients.
- ✱ **Education.** A number of areas requiring education were identified. Patients need information regarding the alternatives available to them for pain management, including the use of various drugs. They also should have an understanding of their personal responsibilities regarding control of their pain, including control of their medications. Physicians should be trained to recognize and deal appropriately with their patients experiencing severe pain, both acute and chronic. Some suggested that the current requirement for AIDS education with renewal of licenses be altered

to a rotation program that would include other special areas, such as pain management.

- **Outcomes Data.** Testimony was presented to reflect a need for comprehensive follow-up data to determine the effectiveness of various pain management techniques. Apparently some facilities involved in pain management do almost no follow-up data collection, while others have elaborate systems. Although a number of studies have been conducted in the various areas of pain management, no major statewide computerized base of pain management data appears to exist. Development and implementation of a statewide system or comparable system would be valuable to research and expansion of the knowledge base for the area of pain management.
- **Grants Funds.** It was suggested that the Commission explore various funding sources, especially grants, to finance potentially costly activities, such as the development of a pain management data base and education of patients and health care providers.
- **Patient Lifestyle.** Suggestion was made that to help meet the needs of patients in pain a variety of factors should be explored, among them whether or not the patient smoked or was on birth control pills.
- **Certification of Pain Specialists.** Note was made that a physician prescribing drugs for chronic pain should have special training and be certified as a "pain specialist." This idea was not supported by those that prefer to have less governmental regulation.
- **Multidisciplinary Approach to Pain Management.** A number of health care providers suggested patients in pain should be evaluated through a team approach and a plan of pain management should be developed to incorporate a variety of services. There were complaints that patients often come to certain providers after they have gone through many surgeries and all else has failed. It is believed that it may be too late at that point to be effective, but earlier intervention could have been very helpful to the patient, perhaps even eliminating the need for surgery. Some pain sufferers noted the vast difference in the success of their treatments when this multidisciplinary approach was used.

Written Testimony. In addition to oral testimony, participants were given an opportunity to present written testimony. The Agency's address was provided for participants to return their comments by mail. AHCA received 18 written testimonies. Additionally, one (1) presenter of oral testimony at the Orlando forum also submitted a lengthy document that included his testimony and supporting materials. The written comments closely mirrored the concerns addressed by the speakers in the three forums.

Summary. Although a number of issues were deemed important by the speakers, three areas of grave concern were recurrent throughout the forums. These were, (1) reimbursement for pain treatment, (2) prescribing of narcotics for pain sufferers, and (3) education of physicians and other health care professionals, pain sufferers and the general public about treatment of pain. Most frequent references to a need for education evolved around the role of narcotics and the possibility of drug dependency, and alternatives to narcotics to manage pain, including the role of surgery in pain management.

Underlying the comments were frequent implications for legislation to officially recognize the management of pain as the treatment of a disease and to deal with the laws regarding narcotics. This was more implied than directly recommended because there is generally a mood throughout the country of less governmental interference. It seems many individuals don't want the government to interfere, but they do want the government to remove the barriers to successful management of pain without opening the door to all sorts of abuse by health care providers.

PAIN MANAGEMENT SURVEY

A survey was prepared by the Commission to help determine attitudes and concerns of health care providers and pain sufferers relating to pain management. The survey was distributed to participants at each forum. Additionally, some of the health care providers in the Miami area also distributed copies of the survey to their patients and colleagues. A total of 128 survey forms were returned for analysis. Eighty-one forms were returned at the forums, 45 forms were received from patients and colleagues of health care providers in Miami and two were received in the mail from individuals submitting written testimony.

The survey was divided into four parts: (1) a general section with 15 items for responses from all participants, (2) a section for responses from health care providers only, (3) a section for responses from pain sufferers only, and (4) a demographic section (optional) for responses from participants regarding age, sex, and race. General responses somewhat mirrored the public testimony. However, the degree of concern expressed regarding some issues varied between the public testimony and the survey responses. Analyses included reviewing the responses in general, as well as by certain groups, such as health care providers and pain sufferers. Where appropriate, responses also were analyzed by types of health care providers, for example medical doctors, nurses and therapists. Selected summary responses are presented below, by parts of the survey, with a narrative section accompanying selected tables of data. Complete results are in the Appendix.

Part I, Items 1-15. This section consisted of 15 statements regarding pain management. Included were issues relating to the roles of specialized pain centers, patients, various health care providers and government in treatment for pain. Participants were asked to respond by circling the number (1-5) that best corresponded to their opinions. Possible responses ranged from strongly agree (5) to strongly disagree (1).

Analysis included computing a weighted average for each response and ranking the 15 statements from highest to lowest average, with averages closest to 5.0 representing the statements of strongest agreement. For comparison, the weighted averages and rankings of pain sufferers and health care providers were also reviewed, in addition to the total group. To see if responses to certain statements reflected the type of health care provider, the statements of medical doctors, therapists and nurses (representing 78% of total health care providers) were also reviewed and ranked.

Table 1
Pain Management Survey, Part I, Items 1-15

	Total n=128		Pain Sufferers n=57		Providers n=74	
	Rank	Wt. Av.	Rank	Wt. Av.	Rank	Wt. Av.
1. All patients have a right to adequate pain management.	1	4.83	2	4.79	1	4.86
5. Health professionals administering pain medications should properly advise patients and caregivers of potential side effects of these medications.	2	4.82	1	4.82	2	4.77
4. Patients and caregivers should be actively involved in deciding the course of a pain management program.	3	4.74	4	4.70	3	4.76
3. There is a need for specialists in the treatment of pain.	4	4.72	3	4.75	4	4.68
2. There is a need for specialized centers for the treatment of pain.	5	4.54	5	4.65	5	4.46
10. Health care providers who treat pain should administer pain assessment questionnaires to their patients.	6	4.33	7	4.26	8	4.36
8. People in pain should receive effective treatment regardless of whether they have a dependency drug problem.	7	4.30	6	4.32	7	4.41
14. Government should protect health providers who treat intractable pain.	8	4.23	8	4.11	6	4.43
6. Licensed health care professionals should monitor pain management programs in the school settings.	9	4.06	9	3.91	9	4.18
13. Government should clarify state laws on intractable pain.	10	4.02	10	3.86	10	4.15
15. Physicians fear prosecution as a result of prescribing narcotics for patients in pain.	11	3.80	11	3.68	12	3.78
12. Government should disseminate accurate information from federal statutes re: intractable pain.	12	3.74	12	3.58	11	3.89
9. Drug addicts should be treated differently for pain.	13	3.10	13	3.33	13	3.09
7. Nurse practitioners should be allowed to prescribe controlled substances.	14	2.73	14	2.72	14	2.74
11. Government should be involved in prescribing pain medications.	15	1.89	15	1.95	15	1.89

As evidenced by the comparative rankings above, pain sufferers and health care providers were very consistent in their assessment of the statements regarding pain management. The first statements (1,2,3,4 & 5), as expected, were rated the highest among all respondents. These were almost "givens" regarding patients' rights and caregivers' responsibilities and the need for more specialists and specialized centers for treatment of pain. The remaining statements were somewhat scrambled in their order of support. Pain sufferers weighted the importance of health care providers administering pain assessment questionnaires (10) a little higher than health care providers, themselves. Respondents were consistent in their concerns for treatment of patients with drug dependency problems, ranking seventh the statement in support of treatment of pain sufferers regardless of drug dependency problems (8) and ranking thirteenth the statement that drug addicts should be treated differently (9). Intractable pain did not appear to be of great concern to most respondents. The statement that government

should protect health providers who treat intractable pain (14) was ranked eighth (sixth by health care providers), the statement that government should clarify state laws on intractable pain (13) was ranked tenth, and the statement that government should disseminate accurate information from federal statutes regarding intractable pain (12) was ranked twelfth. There could be several explanations for this result. One might suspect the word "government" had a great deal to do with the responses, since there was also very negative response to government being involved in prescribing pain medications (11), which was ranked last, at fifteenth. Since both health care providers and pain sufferers were consistent in their feelings regarding intractable pain (remembering, of course, that 13 health care providers were also pain sufferers), ignorance of this subject is not suspected to be a factor. All respondents were consistent in the feelings that nurse practitioners should not be allowed to prescribe controlled substances (7), ranking this statement fourteenth.

Table 2
Pain Management Survey, Part I, Items 1-15

	Medical Drs. n=17		Therapists n=16		Nurses n=25	
	Rank	Wt. Av.	Rank	Wt. Av.	Rank	Wt. Av.
1. All patients have a right to adequate pain management.	1	4.94	1t	4.81	1t	4.88
5. Health professionals administering pain medications should properly advise patients and caregivers of potential side effects of these medications.	4t	4.65	1t	4.81	3	4.72
4. Patients and caregivers should be actively involved in deciding the course of a pain management program.	3	4.71	4	4.75	1t	4.88
3. There is a need for specialists in the treatment of pain.	2	4.76	1t	4.81	4	4.68
2. There is a need for specialized centers for the treatment of pain.	8	4.41	5	4.56	8	4.48
10. Health care providers who treat pain should administer pain assessment questionnaires to their patients.	9t	4.29	6	4.13	5	4.64
8. People in pain should receive effective treatment regardless of whether they have a dependency drug problem.	9t	4.29	7t	4.06	6t	4.60
14. Government should protect health providers who treat intractable pain.	4t	4.65	9	4	6t	4.60
6. Licensed health care professionals should monitor pain management programs in the school settings.	9t	4.29	10	3.81	9	4.20
13. Government should clarify state laws on intractable pain.	6t	4.53	7t	4.06	10	4.16
15. Physicians fear prosecution as a result of prescribing narcotics for patients in pain.	6t	4.53	13	3.31	11t	3.84
12. Government should disseminate accurate information from federal statutes regarding intractable pain.	12	4.18	12	3.44	11t	3.84
9. Drug addicts should be treated differently for pain.	13	3.18	11	3.56	14	2.40
7. Nurse practitioners should be allowed to prescribe controlled substances.	15	1.94	14	2.56	13	3.48
11. Government should be involved in prescribing pain medications.	14	2.06	15	1.63	15	1.64

Responses of the majority of health care providers (78.4%), displayed in the table above, included medical doctors, therapists and nurses. Since the numbers for analysis are smaller, there are frequent ties among the weighted averages, which could cause a little more difficulty interpreting the results. However, there are some obvious variations from the result totals of Table 1. Medical doctors, who are the persons most likely affected by prescribing of narcotics, more strongly agreed that physicians fear prosecution as a result of prescribing narcotics for patients in pain (15) than the general population of participants. They also more strongly agreed that government should protect health providers who treat intractable pain (14). Therapists were also apparently concerned about intractable pain, since they followed the same pattern as physicians, ranking item 14 higher than the ranking of the total population. Nurses more generally followed the patterns of agreement with the total population. It was especially interesting to find that nurses tended to agree with the total population on the statement regarding nurse practitioners being involved in prescribing pain medications (11), ranking it thirteenth.

Part II, Items 16-21. Health care providers were asked to respond to this section. The questions were designed to gather information about the extent of their involvement in pain management. For comparative purposes, respondents were also asked for their professional areas of specialty and types of settings in which they worked.

- * 81.1% (60) indicated they provided pain treatment to their patients. 86.7% (50) of these individuals treated chronic pain patients, with 50% (30) treating acute pain patients and 36.7% (22) treating cancer patients.
- * 74.3% (55) of all health care providers treated over 50% of their patients for pain, with 23.0% (17) treating all of their patients for pain.
- * Only 12.2% (9) of health care providers indicated they feared prosecution as a result of prescribing narcotics for patients in pain. Among the nine (9) respondents, seven (7) were medical doctors and the remaining two (2) did not indicate a profession. The seven (7) medical doctors represented 41.2% of the total (17) medical doctor respondents. This followed the same pattern as the companion statement in Part I — medical doctors are more concerned than others think, but most of them are not overly concerned.
- * 44.6% (33) indicated they had interrupted or terminated pain treatment for a reason other than the patient no longer needed pain relief. Their reasons for terminating treatment are summarized in Table 3 on the following page.

Reason for terminating treatment		Number of respondents		Percentage	
1	Other	1	3.0	1.0	3.0
2	Other	1	3.0	1.0	3.0
3	Other	1	3.0	1.0	3.0
4	Other	1	3.0	1.0	3.0
5	Other	1	3.0	1.0	3.0
6	Other	1	3.0	1.0	3.0
7	Other	1	3.0	1.0	3.0
8	Other	1	3.0	1.0	3.0
9	Other	1	3.0	1.0	3.0
10	Other	1	3.0	1.0	3.0
11	Other	1	3.0	1.0	3.0
12	Other	1	3.0	1.0	3.0
13	Other	1	3.0	1.0	3.0
14	Other	1	3.0	1.0	3.0
15	Other	1	3.0	1.0	3.0
16	Other	1	3.0	1.0	3.0
17	Other	1	3.0	1.0	3.0
18	Other	1	3.0	1.0	3.0
19	Other	1	3.0	1.0	3.0
20	Other	1	3.0	1.0	3.0
21	Other	1	3.0	1.0	3.0
22	Other	1	3.0	1.0	3.0
23	Other	1	3.0	1.0	3.0
24	Other	1	3.0	1.0	3.0
25	Other	1	3.0	1.0	3.0
26	Other	1	3.0	1.0	3.0
27	Other	1	3.0	1.0	3.0
28	Other	1	3.0	1.0	3.0
29	Other	1	3.0	1.0	3.0
30	Other	1	3.0	1.0	3.0
31	Other	1	3.0	1.0	3.0
32	Other	1	3.0	1.0	3.0
33	Other	1	3.0	1.0	3.0
34	Other	1	3.0	1.0	3.0
35	Other	1	3.0	1.0	3.0
36	Other	1	3.0	1.0	3.0
37	Other	1	3.0	1.0	3.0
38	Other	1	3.0	1.0	3.0
39	Other	1	3.0	1.0	3.0
40	Other	1	3.0	1.0	3.0
41	Other	1	3.0	1.0	3.0
42	Other	1	3.0	1.0	3.0
43	Other	1	3.0	1.0	3.0
44	Other	1	3.0	1.0	3.0
45	Other	1	3.0	1.0	3.0
46	Other	1	3.0	1.0	3.0
47	Other	1	3.0	1.0	3.0
48	Other	1	3.0	1.0	3.0
49	Other	1	3.0	1.0	3.0
50	Other	1	3.0	1.0	3.0

Table 3
Part II, Item 18

	Reasons for Terminating Pain Treatment Other Than Patient No Longer Needed	#
1.	Third party intervention problems - insurance (or Medicare/Medicaid) refused to reimburse or canceled reimbursement	11
2.	Failure of the patient to give full effort to comply with pain treatment program.	7
3.	Complicating medical or psychological problems became barriers.	5
4.	Physician problems - primary care physician refused to order appropriate medicine and/or removed patient from program. Strong need for physician education.	5
5.	Patient could not afford to pay and had no insurance coverage.	4
6.	Patient had drug dependency problems that prevented effective treatment.	3
7.	Restrictions within the patient setting (i.e. nursing home or hospice) that prevented the patient from getting adequate medication for treatment of pain.	1
8.	Litigation interfered with patient's progress.	1
9.	The treatment was ineffective.	1

Part II, Item 20. Table 4 (right) lists the health care providers that participated in the survey by their professions. Two health care providers did not indicate a profession and two indicated more than one profession. Five areas of choice were not represented: podiatrist, osteopathic physician, dentist, pharmacist and nurse practitioner.

Table 4	
Health Care Providers	#
Nurses	25
Medical doctors	17
Therapists	16
Chiropractors	5
Psychologists	3
Alternative Specialists	3
Other	5

Certain of the responses requested that health care providers indicate a specialty within the profession. Table 5 below provides the results of the five areas for which specialties were provided.

Table 5
Selected Health Care Providers by Area of Specialty

Medical Doctors		Nurses		Therapists		Alternative Sp.		Other	
Anesthesiology	7	Hospice	6	Physical	6	Acupuncture	1	Rehab Engnr	2
Family Practice	2	Pain Management	6	Occupational	3	Ergonomics	1	Administrator	1
Pain Management	1	Rehabilitation	2	Psychotherapy	2	No response	1	Counselor	1
Rehab./Pain Mgmt.	1	Pain Mgt./Rehab.	1	OT Aide	1			No response	1
Hospice	1	Neuro/Ortho	1	Ex. Physiology	1				
Internal Medicine	1	Ortho/Education	1	Rehab. Couns.	1				
Neonatology	1	Oncology	1	No response	2				
Physical Medicine	1	OR	1						
PMR	1	Crit. Care Case Mgmt.	1						
No response	1	No response	5						
TOTAL	17		25		16		3		5

Part II, Item 21. Health care providers were asked to respond to a check list of types of facilities in which they provided health care. There were 11 options, including an item to indicate another type of facility not included on the list of options. Many health care providers checked more than one type of facility. Table 7 (right) displays the number of responses for each option and the percent of the total health care providers (74) selecting each type of facility.

Table 7		
Health Care Provider - Facilities	#	%
Pain Treatment Facility	34	46.0
Hospital: Inpatient	26	35.1
Hospital: Outpatient	23	31.1
Rehabilitation: Outpatient	18	24.3
Rehabilitation: Inpatient	16	21.6
Office	12	16.2
Hospice	12	16.2
Ambulatory: Outpatient Surgery	5	6.8
Home Health	4	5.4
Ambulatory Care Center	2	2.7
Other	4	5.4

Part III, Items 22-30. Pain sufferers were requested to provide information about their problems with pain and the methods of treatment they had tried. Multiple responses were optional for most areas.

- 68.4% (39) of the 57 pain sufferers reported they suffered from pain frequently (on a daily basis).
- The location of pain sufferers' pain was varied, with many experiencing pain in multiple areas. 61.4% (35) of the group, however, included lower back pain in their choices. The neck at 49.1% (28) and the legs at 40.4% (23) were the next most popular choices. 31.6% (18) of the respondents indicated "other" locations. Of the nine other areas specified, feet (6) were the most frequently cited.
- 68.4% (39) of the pain sufferers described their type pain as chronic. 52.6% (30) described their pain as aching and 42.1% (24) considered their pain severe. These were the most common responses among the 12 options. Only 8.8% (5) considered their pain to be mild.
- 73.7% (42) of the pain sufferers indicated their pain interfered with activities of daily living (such as dressing, eating, bathing, walking, sitting, standing, shopping). 66.7% (38) indicated interference with leisure activities, followed closely by 64.9% (37) reporting interference with sleep and 61.4% (35) reporting interference with work. Only 35.1% (20) indicated pain problems interfered with their driving, and 22.8% (13) reported interference with ability to care for their families, including children. The later response could be a reflection of the ages of many of the respondents.
- 56.1% (32) of the pain sufferers reported using anti-inflammatory medications for their pain, followed by 49.1% (28) using narcotics, 45.6% (26) using muscle relaxants and 42.1% (24) using a variety of over-the-counter drugs. Tylenol (8), Aspirin (4) and Advil (4) led the list of over-the-counter drugs, followed by Motrin (2), Caltrate (1), and Excedrin (1).
- The leading type of treatment for pain was physical therapy at 66.7% (38), followed by massage therapy at 52.6% (30) and counseling and pain treatment facilities, each at 40.4% (23). 28.1% (16) indicated a treatment other than those included on

the survey. Eleven other treatments were reported, including surgery(2) and TENS (2).

- Responses were generally low regarding assessment of treatment, with "unsuccessful" and "disappointing" heading the list at 42.1% (24) each.
- Only one (1) malignant and two (2) non-malignant tumors were reported among the 57 respondents. However, when asked to report the diagnosis given by the patient's health care provider, 32 different conditions were reported. 25 did not respond to the question and 3 indicated their health care providers did not know the cause of their pain.
- 27 pain sufferers who considered their pain treatment inadequate responded to the request to rank in order of importance the statements of possible reasons for the inadequate treatment or poor management of pain. There were five (5) choices, each of which could be ranked in importance: 1, 2, 3, 4, or 5. The responses were weighted with a response of 1 = 5 points, 2 = 4 points, 3 = 3 points, 4 = 2 points and 5 = 1 point, and totaled. Table 8 below presents a summary of the results with the statements ranked in order of weighted totals from highest to lowest.

Table 8 Part III, Item 29 Reasons for Inadequate Treatment for Pain - Ranked		Wt. Total
1. Lack of knowledge of resources available to receive proper treatment of pain.		95
2. Insensitivity or lack of concern for my pain by my health care provider(s).		90
3. Reluctance of my physician to prescribe adequate drugs to treat my pain due to fears of reprimand.		70
4. Deficiencies within state and/or federal laws regarding adequate treatment of pain.		70
5. Lack of appropriate health care providers/facilities to properly treat my pain in my community.		55

Part IV, Items 31 - 33. The respondents to the survey were primarily middle aged (40 to 60), female and white. This was an optional section and several individuals elected not to respond. The summary of the demographic information is contained in Table 9 below.

Table 9 Demographic Information							
Age	#	%	Gender	#	%	Race/Ethnic	# %
Between 40 and 60	63	49.2	Female	65	50.8	White	102 79.7
20 to 40	36	28.1	Male	50	39.1	Hispanic	8 6.3
60 to 75	15	11.7	No response	13	10.2	Black	4 3.1
Over 75	5	3.9				Am. Ind. or Nat. AL	1 0.8
Under 20	0	0.0				Asian or Pacific Is.	0 0.0
No response	9	7.0				Other	1 0.8
						No response	12 9.4

RECOMMENDATIONS

The Pain Management Commission urges the Florida Legislature to endorse the recommendations listed below and, in cooperation with members of the Commission and other medical professionals, (1) actively seek the appropriate legislative action for recommendations requiring statutory revision, and (2) actively engage in dialogue among federal officials and appropriate statewide boards and agencies to promulgate enactment of rules and laws for recommendations requiring joint state and federal approval.

The Pain Management Commission recommends the following:

1. **CONTINUE FUNDING AND RECOGNITION OF THE PAIN MANAGEMENT COMMISSION AS A VOLUNTARY RESOURCE TO THE STATE OF FLORIDA WITH REGARD TO PAIN MANAGEMENT, WHICH PERIODICALLY MAY BE CALLED UPON IN AN ADVISORY OR EDUCATIONAL CAPACITY TO ASSIST POLICYMAKERS, HEALTH CARE PROFESSIONALS AND THE GENERAL PUBLIC.**

This would provide for the Commission to be called upon to serve in an advisory capacity to the Department of Health, Department of Insurance, Agency for Health Care Administration, including all health related boards, and serve as an educational and informational body to the Governor, Legislature, professional medical associations and the general public.

2. **ALL CITIZENS OF THE STATE OF FLORIDA HAVE THE RIGHT OF ACCESS TO TREATMENT FOR RELIEF OF PAIN.**

This would provide official recognition of the rights of pain sufferers of access to services for treatment for relief of pain.

3. **RECOGNIZE CHRONIC PAIN AS A LEGITIMATE CONDITION WITH APPROPRIATE CODING FOR SERVICES.**

This would provide for reimbursement by groups which may include private insurers, Medicare, Medicaid, Workers' Compensation and others.

4. **PROVIDE MORE FLEXIBILITY TO PHYSICIANS WHEN PRESCRIBING OR TREATING PATIENTS FOR PAIN.**

This would seek to reduce physicians' fear of administrative action when prescribing in the regular course of their professions to their patients when the prescription is issued after a good faith examination and there is medical indication for the treatment.

5. **PROVIDE FOR A CENTRALIZED STATEWIDE REGISTRY OF PAIN MANAGEMENT CENTERS THAT WOULD INCLUDE A DESCRIPTION OF THE SERVICES PROVIDED BY EACH CENTER.**

This information would be made available to medical professionals and the general public for use as a reference guide to available pain management services.

6. PROVIDE FOR AND ENCOURAGE PARTICIPATION IN PAIN MANAGEMENT EDUCATIONAL PROGRAMS FOR PHYSICIANS, OTHER HEALTH CARE PROVIDERS, AND PAIN SUFFERERS AND THEIR FAMILIES.

This would seek to reduce the pain suffered unnecessarily each year by thousands of individuals through ignorance or misunderstandings on the part of these individuals and/or their physicians or other health care providers.

7. PROVIDE FOR A CLEARINGHOUSE ON PAIN MANAGEMENT INFORMATION, INCLUDING PATIENT INFORMATION, PROFESSIONAL TRAINING PROGRAMS, PAIN MANAGEMENT GUIDELINES, AND RESEARCH-BASED OUTCOMES.

Information would be collected and disseminated to health care professionals, pain sufferers and their families, and policymakers, as well as the general public.

8. PROVIDE FOR PAIN MANAGEMENT RESEARCH, DEVELOPMENT OF A STATEWIDE DATA BASE OF OUTCOMES DATA, AND TECHNOLOGY TO ACCESS OTHER NATIONAL DATABASES, SUCH AS THOSE AVAILABLE THROUGH THE INTERNET OR OTHER MAJOR NETWORKS.

This technology would provide a means to tap the base of knowledge regarding pain management and maximize the ability of health care professionals to improve the quality of life for pain sufferers.

9. PROMOTE THE TEACHING OF PAIN MANAGEMENT AS AN INTEGRAL COMPONENT OF THE CURRICULA OF SCHOOLS FOR HEALTH CARE PROFESSIONALS, INCLUDING, BUT NOT LIMITED TO, MEDICAL, OSTEOPATHY, CHIROPRACTIC, NURSING, PHARMACY, AND DENTAL SCHOOLS.

Although most health care professionals will routinely be involved in the treatment and management of patients with pain, school curricula for health care professionals typically do not include pain management techniques. This would establish the importance of training in pain management.

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PAIN MANAGEMENT SURVEY

APPENDIX

Summary Report

Survey Participants

SUMMARY OF SURVEY RESULTS

REPORT: TALLAHASSEE FORUM

REPORT: ORLANDO FORUM

REPORT: MIAMI FORUM

1. All patients have a right to adequate pain management.

Strongly Disagree	1	0	0.0	0	0.0	0	0.0	0	0.0
Disagree	2	0	0.0	0	0.0	0	0.0	0	0.0
No Opinion	3	1	0.8	0	0.0	1	1.8	0	0.0
Agree	4	20	15.8	10	13.5	10	17.5	2	20.0
Strongly Agree	5	107	83.6	64	86.5	40	80.7	8	80.0
Weighted Average			4.83		4.65		4.79		4.60

2. There is a need for specialized centers for the treatment of pain.

Strongly Disagree	1	2	1.6	2	2.7	0	0.0	0	0.0
Disagree	2	3	2.3	1	1.4	1	1.8	1	10.0
No Opinion	3	9	7.0	6	8.1	2	3.6	1	10.0
Agree	4	24	18.8	17	23.0	18	22.8	2	20.0
Strongly Agree	5	60	46.3	48	64.8	40	71.9	6	60.0
Weighted Average			4.54		4.48		4.83		4.30

3. There is a need for specialists in the treatment of pain.

Strongly Disagree	1	1	0.8	1	1.4	0	0.0	0	0.0
Disagree	2	1	0.8	0	0.0	1	1.8	0	0.0
No Opinion	3	2	1.5	2	2.7	2	3.6	0	0.0
Agree	4	25	19.5	16	21.5	11	19.3	3	30.0
Strongly Agree	5	86	66.3	55	74.3	46	79.0	7	70.0
Weighted Average			4.72		4.66		4.76		4.7

APPENDIX

SUMMARY OF SURVEY RESULTS

REPORT: TALAHASSEE FORUM

REPORT: ORLANDO FORUM

REPORT: MIAMI FORUM

PAIN MANAGEMENT SURVEY

Summary Report

Survey Participants

Total Participants

128

Health Care Providers	74
Pain Sufferers	57
Other	10
Health Care Providers & Pain Sufferers (both)	13

PART 1, Items 1-15

	Total		Health Care Providers		Pain Sufferers		Others	
	#	%	#	%	#	%	#	%
	128	100	74	100	57	100	10	100

1. All patients have a right to adequate pain management.

Strongly Disagree	1	0	0.0	0	0.0	0	0.0	0	0.0
Disagree	2	0	0.0	0	0.0	0	0.0	0	0.0
No Opinion	3	1	0.8	0	0.0	1	1.8	0	0.0
Agree	4	20	15.6	10	13.5	10	17.5	2	20.0
Strongly Agree	5	107	83.6	64	86.5	46	80.7	8	80.0
Weighted Average			4.83		4.86		4.79		4.80

2. There is a need for specialized centers for the treatment of pain.

Strongly Disagree	1	2	1.6	2	2.7	0	0.0	0	0.0
Disagree	2	3	2.3	1	1.4	1	1.8	1	10.0
No Opinion	3	9	7.0	6	8.1	2	3.5	1	10.0
Agree	4	24	18.8	17	23.0	13	22.8	2	20.0
Strongly Agree	5	90	70.3	48	64.9	41	71.9	6	60.0
Weighted Average			4.54		4.46		4.65		4.30

3. There is a need for specialists in the treatment of pain.

Strongly Disagree	1	1	0.8	1	1.4	0	0.0	0	0.0
Disagree	2	1	0.8	0	0.0	1	1.8	0	0.0
No Opinion	3	2	1.6	2	2.7	0	0.0	0	0.0
Agree	4	25	19.5	16	21.6	11	19.3	3	30.0
Strongly Agree	5	99	77.3	55	74.3	45	79.0	7	70.0
Weighted Average			4.72		4.68		4.75		4.7

PART 1, Items 1-15 continued

	Total		Health Care Providers		Pain Sufferers		Others		
	#	%	#	%	#	%	#	%	
	128	100	74	100	57	100	10	100	
4. Patients and caregivers should be actively involved in deciding the course of a pain management program.									
Strongly Disagree	1	0	0.0	0	0.0	0	0.0	0	0.0
Disagree	2	1	0.8	1	1.4	0	0.0	0	0.0
No Opinion	3	0	0.0	0	0.0	0	0.0	0	0.0
Agree	4	30	23.4	15	20.3	17	29.8	2	20.0
Strongly Agree	5	97	75.8	58	78.4	40	70.2	8	80.0
Weighted Average			4.74		4.76		4.70		4.8
5. Health professionals administering pain medications should properly advise patients.									
Strongly Disagree	1	0	0.0	0	0.0	0	0.0	0	0.0
Disagree	2	0	0.0	0	0.0	0	0.0	0	0.0
No Opinion	3	1	0.8	0	0.0	1	1.8	0	0.0
Agree	4	21	16.4	17	23.0	8	14.0	0	0.0
Strongly Agree	5	106	82.8	57	77.0	48	84.2	10	100
Weighted Average			4.82		4.77		4.82		5.00
6. Licensed health care professionals should monitor pain management programs in the school settings.									
Strongly Disagree	1	1	0.8	0	0.0	1	1.8	0	0.0
Disagree	2	3	2.3	0	0.0	3	5.3	0	0.0
No Opinion	3	34	26.6	18	24.3	16	28.1	2	20.0
Agree	4	39	30.5	25	33.8	17	29.8	3	30.0
Strongly Agree	5	51	39.8	31	41.9	20	35.1	5	50.0
Weighted Average			4.06		4.18		3.91		4.3
7. Nurse practitioners should be allowed to prescribe controlled substances.									
Strongly Disagree	1	27	21.1	15	20.3	11	19.3	2	20.0
Disagree	2	31	24.2	20	27.0	14	24.6	2	20.0
No Opinion	3	32	25.0	17	23.0	16	28.1	3	30.0
Agree	4	25	19.5	13	17.6	12	21.1	3	30.0
Strongly Agree	5	13	10.2	9	12.2	4	7.0	0	0.0
Weighted Average			2.73		2.74		2.72		2.70

PART 1, Items 1-15 continued

	Total		Health Care Providers		Pain Sufferers		Others		
	#	%	#	%	#	%	#	%	
	128	100	74	100	57	100	10	100	
8. People in pain should receive effective treatment regardless of whether they have a dependency drug problem.									
Strongly Disagree	1	3	2.3	1	1.4	1	1.8	1	10.0
Disagree	2	5	3.9	2	2.7	1	1.8	2	20.0
No Opinion	3	7	5.5	2	2.7	4	7.0	1	10.0
Agree	4	49	28.3	30	40.5	24	42.1	3	30.0
Strongly Agree	5	64	50.0	39	52.7	27	47.4	3	30.0
Weighted Average			4.30		4.41		4.32		3.50
9. Drug addicts should be treated differently for pain.									
Strongly Disagree	1	17	13.3	13	17.6	3	5.3	1	10.0
Disagree	2	31	24.2	14	18.9	14	24.6	4	40.0
No Opinion	3	19	14.8	9	12.2	9	15.8	3	30.0
Agree	4	44	34.4	29	39.2	23	40.4	1	10.0
Strongly Agree	5	17	13.3	9	12.2	8	14.0	1	10.0
Weighted Average			3.10		3.09		3.33		2.7
10. Health care providers who treat pain should administer pain assessment questionnaires to their patients.									
Strongly Disagree	1	2	1.6	1	1.4	2	3.5	0	0.0
Disagree	2	1	0.8	0	0.0	1	1.8	0	0.0
No Opinion	3	11	8.6	7	9.5	5	8.8	1	10.0
Agree	4	53	41.4	29	39.2	21	36.8	5	50.0
Strongly Agree	5	61	47.7	37	50.0	28	49.1	4	40.0
Weighted Average			4.33		4.36		4.26		4.30
11. Government should be involved in prescribing pain medications.									
Strongly Disagree	1	59	46.1	35	47.3	25	43.9	3	30.0
Disagree	2	41	32.0	23	31.1	18	31.6	5	50.0
No Opinion	3	16	12.5	8	10.8	9	15.8	2	20.0
Agree	4	7	5.5	5	6.8	2	3.5	0	0.0
Strongly Agree	5	5	3.9	3	4.1	3	5.3	0	0.0
Weighted Average			1.89		1.89		1.95		1.9

PART I, Items 1-15 continued

		Total		Health Care Providers		Pain Sufferers		Others	
		#	%	#	%	#	%	#	%
		128	100.	74	100.	57	100.	10	100.
			0		0		0		0
12. Government should disseminate accurate information from federal statutes regarding tractable pain.									
Strongly Disagree	1	4	3.1	3	4.1	2	3.5	0	0.0
Disagree	2	13	10.2	8	10.8	6	10.5	2	20.0
No Opinion	3	30	23.4	9	12.2	20	35.1	2	20.0
Agree	4	46	35.9	28	37.8	15	26.3	5	50.0
Strongly Agree	5	35	27.3	26	35.1	14	24.6	1	10.0
Weighted Average			3.74		3.89		3.58		3.50
13. Government should clarify state laws on intractable pain.									
Strongly Disagree	1	3	2.3	0	0.0	2	3.5	1	10.0
Disagree	2	4	3.1	3	4.1	2	3.5	0	0.0
No Opinion	3	28	21.9	15	20.3	16	28.1	2	20.0
Agree	4	45	35.2	24	32.4	19	33.3	5	50.0
Strongly Agree	5	48	37.5	32	43.2	18	31.6	2	20.0
Weighted Average			4.02		4.15		3.86		3.70
14. Government should protect health care providers who treat intractable pain.									
Strongly Disagree	1	1	0.8	0	0.0	1	1.8	0	0.0
Disagree	2	1	0.8	0	0.0	1	1.8	0	0.0
No Opinion	3	25	19.5	10	13.5	10	17.5	5	50.0
Agree	4	41	32.0	22	29.7	24	42.1	3	30.0
Strongly Agree	5	60	46.9	42	56.8	21	36.8	2	20.0
Weighted Average			4.23		4.43		4.11		3.70
15. Physicians fear prosecution as a result of prescribing narcotics for patients in pain.									
Strongly Disagree	1	0	0.0	0	0.0	0	0.0	0	0.0
Disagree	2	13	10.2	8	10.8	8	14.0	0	0.0
No Opinion	3	37	28.9	19	25.7	19	33.3	5	50.0
Agree	4	41	32.0	28	37.8	13	22.8	3	30.0
Strongly Agree	5	37	28.9	19	25.7	17	29.8	2	20.0
Weighted Average			3.80		3.78		3.68		3.70

PART II, Items 16-21 Health Care Providers

		Health Care Providers	
		#	%
		74	100
16. Do you provide pain treatment yourself?			
	YES	60	81.1
	NO	14	18.9
	YES: Chronic	52	86.7
	Acute	30	50.0
	Cancer	22	36.7
17. Percentage of patients requiring pain treatment:			
	75% to 100%	33	44.6
	All PM patients	17	23.0
	50% to 75%	5	6.8
	ZERO	3	4.1
	Under 25%	3	4.1
	25% to 50%	3	4.1
	No response	10	13.5
18. Have you interrupted or terminated pain treatment for a reason other than the patient no longer needed pain relief?			
	YES	33	44.6
	NO	25	33.8
	NA	16	21.6
	YES: Reasons:		
	Insurance (or Medicare/Medicaid) canceled or refused payment	11	33.3
	Patient failed to comply or give full effort	7	21.2
	Complicating medical or psychological problems	5	15.2
	Physician refused to order appropriate medication/removed patient	5	15.2
	Patient unable to pay/no insurance coverage	4	12.1
	Patient had drug dependency problems	3	9.1
	Nursing home/hospice restrictions prevented proper medication	2	6.1
	Litigation interfered with patient's progress	1	3.0
	Treatment was ineffective	1	3.0
19. Do you fear prosecution as a result of prescribing narcotics for patients in pain?			
	NO	18	24.3
	YES	9	12.2
	NA	47	63.5

PART II, Items 16-21 Health Care Providers

Health Care
Providers

#	%
74	100

20. Professional Information:

NURSE	25	33.8
-------	----	------

Hospice	6	24.0
Pain	6	24.0
Management		
Rehabilitation	2	8.0
Pain	1	4.0
Mgt./Rehab.		
Neuro/Ortho	1	4.0
Orthopedics/Ed.	1	4.0
Oncology	1	4.0
OR	1	4.0
Crit. Care Case Mgt.	1	4.0
No response	5	20.0

MEDICAL DOCTOR	17	23.0
----------------	----	------

Anesthesiology	7	41.2
Family Practice	2	11.8
Pain	1	5.9
Management		
Rehab./Pain	1	5.9
Mgt.		
Hospice	1	5.9
Internal	1	5.9
Medicine		
Neonatology	1	5.9
Physical	1	5.9
Medicine		
PMR	1	5.9
No response	1	5.9

THERAPIST	16	21.6
-----------	----	------

Physical	6	37.5
Occupational	3	18.8
Psychotherapy	2	12.5
OT Aide	1	6.3
Ex. Physiology	1	6.3
Rehab.	1	6.3
Counselor		
No response	2	12.5

CHIROPRACTOR	5	6.8
--------------	---	-----

PSYCHOLOGIST	3	4.1
--------------	---	-----

PART II, Items 16-21 Health Care Providers

20. Professional Information (cont.):

ALTERNATIVE SPECIALIST

Acupuncture	1	33.3
Ergonomics	1	33.3
No response	1	33.3

PODIATRIST

OSTEOPATH¹

DENTIST

PHARMACIST

PSYCHOLOGIST

NURSE PRACTITIONER

OTHER

Rehab.	2	40.0
Engineer		
Administrator	1	20.0
Counselor	1	20.0
No response	1	20.0

NO RESPONSE

21. Type of facility in which you practice:

Pain treatment facility	34	46.0
Hospital: Inpatient	26	35.1
Hospital: Outpatient	23	31.1
Rehabilitation: Outpatient	18	24.3
Rehabilitation: Inpatient	16	21.6
Office	12	16.2
Hospice	12	16.2
Ambulatory: Outpatient Surg.	5	6.8
Home Health	4	5.4
Ambulatory: Care Center	2	2.7
Other	4	5.4

¹ Should have read "OSTEOPATHIC PHYSICIAN"

PART III, Items 22-30 Pain Sufferers

22. Suffer from pain:

Frequently
Routinely
Occasionally
Rarely
No pain
problem

Pain Sufferers

#	%
57	100

39	68.4
9	15.8
8	14.0
1	1.8
0	0.0

23. Pain is located:

Lower back
Neck
Legs
Upper back
Knees
Buttocks
Head
Arms
Other

Feet
Hip
Ankle
Hands
Shoulder
Abdomen
Coccyx
Face
Groin
Head
Lower Pelvis/Perineal
Shin
Total body

35	61.4
28	49.1
23	40.4
18	31.6
14	24.6
14	24.6
12	21.1
9	15.8
18	31.6

6
3
2
2
2
1
1
1
1
1
1
1
1

24. Pain is:

TYPE:
Chronic
Acute

39	68.4
15	26.3

SENSITIVITY:

Aching
Burning
Sharp
Numbing
Dull

30	52.6
24	42.1
24	42.1
17	29.8
11	19.3

SEVERITY:
Severe

24	42.1
----	------

PART III, Items 22-30 Pain Sufferers

		Pain Sufferers	
		#	%
		57	100
24. Pain is (cont.):			
	Moderate	21	36.8
	Incapacitating	13	22.8
	Mild	5	8.8
25. Pain interferes with:			
	Daily living activities	42	73.7
	Enjoy leisure hours	38	66.7
	Sleeping	37	64.9
	Working	35	61.4
	Driving	20	35.1
	Caring for children/family	13	22.8
	Other	8	14.0
	Lifestyle/normal life	4	
	Everything	3	
	Painting Portraits	1	
	Sexual activity	1	
26. Type of medications received for pain:			
	Anti-inflammatory	32	56.1
	Narcotics	28	49.1
	Muscle relaxants	26	45.6
	Over-the-counter	24	42.1
	Tylenol	8	
	Aspirin	4	
	Advil	4	
	Motrin	2	
	Caltrate	1	
	Excedrin	1	
	No response	7	
27. Type of treatment(s) received for pain:			
	Physical Therapy	38	66.7
	Massage Therapy	30	52.6
	Counseling	23	40.4
	Pain treatment facility	23	40.4
	Biofeedback	19	33.3
	Visual imagery	14	24.6
	Other	16	28.1
	Surgery	2	
	TENS	2	
	Chiropractic	1	
	Dorsal coli stimulator	1	
	Ex. Physiology	1	
	Ice	1	
	Interferential simulator	1	

PART III, Items 22-30 Pain Sufferers

Pain Sufferers	
#	%
57	100

27. Type of treatment(s) received for pain:

Moist heat	1
Physical Rehab	1
Spinal blocks	1
Support group	1

28. Assessment of treatment(s) received for pain:

Unsuccessful	24	42.1
Disappointing	24	42.1
Successful	18	31.6
Adequate	10	17.5
Exceptional	7	12.3
Insensitive	6	10.5
Sensitive	3	5.3

29. SEE END OF # 30

30. Diagnosis by health care provider:

RSD/RSDS	4	7.0
Myofascial syndrome	3	5.3
Arthritis/osteoarthritis	2	3.5
Disc bulge/herniated disc	2	3.5
Migraine headaches	2	3.5
Arachnoiditis	1	1.8
Arthropathy	1	1.8
Atypical glossopharyngeal neuralgia	1	1.8
Carotidymia	1	1.8
Chronic intractable pain	1	1.8
Drugs(AZT)	1	1.8
HNP	1	1.8
Lower back syndrome	1	1.8
Lumbar/coccyx pain	1	1.8
Myopathy	1	1.8
Nerve damage	1	1.8
Neuralgia	1	1.8
NICO	1	1.8
Neurological	1	1.8
Neuropathy	1	1.8
Post Laminectomy syndrome w/ radiculopathy	1	1.8
Radiculopathy	1	1.8

PART III, Items 22-30 Pain Sufferers

Pain Sufferers	
#	%
57	100

30. Diagnosis by health care provider (cont.):

Recurrent bowel obstruction from adhesions	1	1.8
Rotator cuff - partial tear	1	1.8
Scoliosis	1	1.8
Secondary trigger point muscle spasms	1	1.8
Shingles	1	1.8
Spasms of knee	1	1.8
Strain	1	1.8
Stress	1	1.8
Suicidal depression	1	1.8
Swollen submandibular gland	1	1.8
No diagnosis/can't diagnose	3	5.3
No response	25	43.9
If Diagnosis TUMOR:		
Nonmalignant	2	3.5
Malignant (cancer)	1	1.8

29. Consider treatment inadequate - ranked least(1) to most (5) important and weighted

Lack of knowledge of resources to receive proper treatment for pain. 25 95

Rank	#	wt	total
1	14	5	70
2	3	4	12
3	2	3	6
4	1	2	2
5	5	1	5
weighted total			95

PART III, Items 22-30 Pain Sufferers

Pain Sufferers

#	%
57	100

29. Consider treatment inadequate - ranked least(1) to most (5) important and weighted

Insensitivity or lack of concern for my pain by my health care provider.

23 90

Rank	#	wt	total
1	13	5	65
2	2	4	8
3	4	3	12
4	1	2	2
5	3	1	3
weighted total			90

Reluctance of my physician to prescribe adequate drugs to treat my pain due to fears of reprimand.

21 70

Rank	#	wt	total
1	8	5	40
2	3	4	12
3	3	3	9
4	2	2	4
5	5	1	5
weighted total			70

Deficiencies within state and/or federal laws regarding adequate treatment of pain.

22 70

Rank	#	wt	total
1	9	5	45
2	0	4	0
3	4	3	12
4	4	2	8
5	5	1	5
weighted total			70

Lack of appropriate health care providers/facilities to properly treat my pain in my community.

17 55

Rank	#	wt	total
1	6	5	30
2	2	4	8
3	4	3	12
4	0	2	0
5	5	1	5
weighted total			55

PART IV, Items 31-33

Total		Health Care Providers		Pain Sufferers		Others	
#	%	#	%	#	%	#	%
128	100.0	74	100.0	57	100.0	10	100.0
	0		0		0		0

31 Age:

Between 40 & 60	63	49.2	45	60.8	20	35.1	4	40.0
20 to 40	36	28.1	23	31.1	14	24.6	4	40.0
60 to 70	15	11.7	2	2.7	13	22.8	1	10.0
Over 75	5	3.9	0	0.0	5	8.8	0	0.0
Under 20	0	0.0	0	0.0	0	0.0	0	0.0
No response	9	7.0	4	5.4	5	8.8	1	10.0

32 Gender:

Female	65	50.8	39	52.7	29	50.9	2	20.0
Male	50	39.1	30	40.5	21	36.8	6	60.0
No response	13	10.2	5	6.8	7	12.3	2	20.0

33 Race:

White	102	79.7	58	78.4	46	80.7	8	80.0
Hispanic	8	6.3	8	10.8	1	1.8	0	0.0
Black	4	3.1	1	1.4	2	3.5	1	10.0
Am. Indian/Native AL	1	0.8	0	0.0	1	1.8	0	0.0
Asian/Pacific Islander	0	0.0	0	0.0	0	0.0	0	0.0
Other	1	0.8	1	1.4	0	0.0	0	0.0
No response	12	9.4	6	8.1	7	12.3	1	10.0

- Massage Therapists (and other therapists)
- Chiropractors
- Osteopathic Physicians

Recommendation # 2: Special types of pain that should be addressed by the Commission

- Pediatric pain
- Geriatric pain
- Labor pain

Recommendation # 3: issues that should be addressed by the Commission

- Guidelines for Pain Management. Guidelines were frequently referenced when there appeared a need for communications or education. Hospice care providers cited numerous occasions when physicians refused or were slow to prescribe adequate medication to their patients in hospices; either through fear of reprimand or ignorance of appropriate treatment for pain. It was believed that guidelines might eliminate some of these problems. This was also true in discussions supporting a

Age	Gender	Race	Health Care Providers				Other			
			Physician	Nurse	Other Health	Other	Physician	Nurse	Other Health	Other
21	Age:		0	0	0	0	0	0	0	0
22	Between 40 & 50		48.2	48.2	48.2	48.2	48.2	48.2	48.2	48.2
23	50 to 60		36.7	36.7	36.7	36.7	36.7	36.7	36.7	36.7
24	60 to 70		15.7	15.7	15.7	15.7	15.7	15.7	15.7	15.7
25	Over 70		8.2	8.2	8.2	8.2	8.2	8.2	8.2	8.2
26	Under 20		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
27	No response		9.7	9.7	9.7	9.7	9.7	9.7	9.7	9.7
28	Gender:									
29	Female		68.2	68.2	68.2	68.2	68.2	68.2	68.2	68.2
30	Male		30.7	30.7	30.7	30.7	30.7	30.7	30.7	30.7
31	No response		10.7	10.7	10.7	10.7	10.7	10.7	10.7	10.7
32	Race:									
33	White		100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
34	Hispanic		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
35	Black		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
36	Am. Indian/Alaskan		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
37	Asian/Pacific Islander		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
38	Other		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
39	No response		12.7	12.7	12.7	12.7	12.7	12.7	12.7	12.7
40										
41										
42										
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REPORT: PAIN MANAGEMENT FORUM

Tallahassee, Florida

April 6, 1995

The first of three public forums sponsored by the Pain Management Commission was held in Tallahassee, Florida on April 6, 1995 at the Florida State Library (R.A Gray Building). Dr. Hubert Rosomoff, Vice Chairman, served as moderator of the forum. Dr. Rosomoff and eight (8) other commissioners served as panel members. Assisting with the meeting were staff members of the Agency for Health Care Administration and the Local Health Council. The purpose of the forum was to receive testimony from health care providers, pain sufferers and other interested parties related to pain management. The Pain Management Commission strongly believes that input from these groups is an important first step in the process of appropriately assessing the status of pain management in Florida and formalizing policy and recommendations to the Florida Legislature

PUBLIC TESTIMONY

Fifteen (15) of the 23 individuals attending the forum presented oral testimony. Most of the speakers were health care providers or advocates. Areas represented included pediatrics, hospice, anesthesiology and geriatrics, as well as pain management clinics.

Three (3) speakers were pain sufferers. Testimonies tended to focus on three general areas: (1) health practitioners that the speakers believed should be recognized and included in any formal recommendations relevant to pain management, (2) special types of pain that speakers thought should be recognized, and (3) issues the speakers believed should be addressed by the Commission.

Recommendation # 1: Health practitioners that should be included in pain management strategies

- ✱ Massage Therapists (and other therapists)
- ✱ Chiropractors
- ✱ Osteopathic Physicians

Recommendation # 2: Special types of pain that should be addressed by the Commission

- ✱ Pediatric pain
- ✱ Geriatric pain
- ✱ Labor pain

Recommendation # 3: Issues that should be addressed by the Commission

- ✱ ***Guidelines for Pain Management.*** Guidelines were frequently referenced when there appeared a need for communications or education. Hospice care providers cited numerous occasions when physicians refused or were slow to prescribe adequate medication to their patients in hospices; either through fear of reprimand or ignorance of appropriate treatment for pain. It was believed that guidelines might eliminate some of these problems. This was also true in discussions supporting a

multidisciplinary approach to managing patients in pain regulation or standardization of pain management facilities.

- **Narcotics.** There was general agreement that a number of alternatives to narcotics are available for chronic pain, but there are a few patients for whom nothing else can be done to relieve their pain. The issues involve both federal and state guidelines for prescriptions for certain types of patients, including those covered by Medicare and Medicaid. There was general agreement that physicians do not have as many problems prescribing narcotics for terminally ill cancer patients.
- **Reimbursement.** This seems to be a major issue among most health care providers. Reimbursement problems emerged in many of the testimonies. Both federal and state reimbursement guidelines are involved. Reimbursement in pain management centers is especially troublesome. Problems involve private insurers, including fee-for-service and managed care, as well as Medicare, Medicaid and Workers' Compensation.
- **Regulation of Pain Management Centers.** Pain sufferers, speaking from poor experiences, expressed the belief that pain management centers should under some type of regulation and/or accreditation. Commission panel member informed the group that only existing accreditation currently available to these centers is through other accrediting organizations, such as the Commission on Accreditation of Rehabilitation Facilities (CARF) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO). Accreditation would only apply to those centers with facilities and programs specific to these organizations. Various testimonies revealed wide differences among pain management centers. It was believed that there should be common definitions of terms, such as "multidisciplinary," and, at least, guidelines for establishing of pain management centers.
- **Education.** Testimony cited a need for education of both physicians and pain sufferers. Education should include their rights and responsibilities regarding pain management, including the role of narcotics and other drugs.

Pain Management Forum Tallahassee Summary of Survey Results

QUESTIONS		# RESPONSES					WT.	
	SCALE:	1	2	3	4	5	Avg.	Rank
1.	All patients have a right to adequate pain management.	0	0	0	0	13	5.00	1
2.	There is a need for specialized centers for the treatment of pain.	1	0	2	1	9	4.31	9t
3.	There is a need for specialists in the treatment of pain.	0	0	0	1	12	4.92	2
4.	Patients and caregivers should be actively involved in deciding the course of a pain management program.	0	0	0	3	10	4.77	5
5.	Health professionals administering pain medications should properly advise patients and caregivers of potential side effects of these medications.	0	0	0	2	11	4.85	3t
6.	Licensed health care professionals should monitor pain management programs in the school settings.	0	0	2	3	8	4.46	7t
7.	Nurse practitioners should be allowed to prescribe controlled substances.	2	3	0	6	2	3.23	14
8.	People in pain should receive effective treatment regardless of whether they have a dependency drug problem.	1	0	0	3	9	4.46	7t
9.	Drug addicts should be treated differently for pain.	3	2	0	3	5	3.38	13
10.	Health care providers who treat pain should administer pain assessment questionnaires to their patients.	0	0	0	2	11	4.85	3t
11.	Government should be involved in prescribing pain medications.	8	3	1	1	0	1.62	15
12.	Government should disseminate accurate information from federal statutes regarding intractable pain.	0	1	2	4	6	4.15	11
13.	Government should clarify state laws on intractable pain.	1	0	1	3	8	4.31	9t
14.	Government should protect health providers who treat intractable pain.	0	0	2	2	9	4.54	6
15.	Physicians fear prosecution as a result of prescribing narcotics for patients in pain.	0	1	1	8	3	4.00	12

RESPONSES: ARE YOU A HEALTH CARE PROVIDER? YES (8) NO (5)

16. Do you provide pain treatment yourself?
(7) YES (1) NO (check all that apply) (5) ACUTE (5) CHRONIC (6) CANCER

17. The percentage of your patients requiring pain treatment is: (check only one)
(0) ZERO (0) Under 25% (0) 25% to 50% (0) Between 50% and 75% (5) 75% to 100% (2) All PM patients.

18. Have you interrupted or terminated pain treatment for a reason other than the patient no longer needed pain relief?
(2) YES (4) NO (0) NA If YES, specify reason: _____

19. Do you fear prosecution as a result of prescribing narcotics for patients in pain? (check only one)
(2) YES (0) NO (4) NA

20. Professional Information: (check and complete as applicable)
(3) Medical Doctor-specialty: _____ (0) Chiropractor (0) Podiatrist (0) Osteopath²
(0) Dentist (0) Pharmacist (0) Psychologist (0) Therapist-specialty: _____
(5) Nurse-specialty: (3-Hospice, 1-O.R., 1-Pain Mgt.) (0) Nurse Practitioner-specialty: _____
(0) Alternative specialist (type) _____ (0) Other (specify) _____

21. Type of facility in which you provide health care: (check as applicable)
(2) Office (1) Pain treatment facility (4) Hospice (1) Home health
Hospital: (4) inpatient (2) outpatient Ambulatory: (0) care center (2) outpatient surgery center
Rehabilitation facility: (0) inpatient (0) outpatient (0) Other (specify) _____

² Should have read "Osteopathic Physician"

RESPONSES: DO YOU SUFFER FROM PAIN? YES (3) NO (10)

22. I suffer from pain: (0) no pain problem (0) rarely (0) occasionally (0) routinely (3) frequently
23. The pain that bothers me is located: (1) head (2) neck (1) upper back (2) lower back (0) arms (2) legs (1) knees (0) buttocks (1) other (Face)
24. The pain is : (1) acute (3) chronic (0) dull (1) aching (2) burning (2) sharp (1) numbing (0) mild (0) moderate (3) severe (0) incapacitating
25. My pain interferes with: (2) ability to sleep (3) ability to work (0) driving (3) activities of daily living
(2) ability to enjoy leisure hours (0) ability to care for children/family (1) other (Travel)
26. The type of medication(s) I have received for pain: (check all that apply)
(1) narcotics (3) anti-inflammatory (2) muscle relaxants (2) over-the-counter (Tylenol, Advil)
27. The type of treatment(s) I have received for pain: (check all that apply)
(2) physical therapy (1) counseling (1) biofeedback (1) visual imagery (1) massage therapy
(3) pain treatment facility (1) other (Acupuncture, Chiropractic)
28. My assessment of the treatment(s) I have received for pain (check all that apply): (1) successful
(1) unsuccessful (3) exceptional (0) adequate (0) disappointing (1) sensitive (0) insensitive
Do you consider your treatment inadequate? YES - Go to item 29 NO - Skip to item 30.
29. I attribute any inadequate treatment(s) or poor management of my pain to: (rank your responses (1 to 5) with 1 representing your most important reason and 5 representing your least important reason.)
_____ Insensitivity or lack of concern for my pain by my health care provider(s).
_____ Lack of knowledge of resources available to receive proper treatment for pain.
(1) #2 Lack of appropriate health care providers/facilities to properly treat my pain in my community.
_____ Reluctance of my physician to prescribe adequate drugs to treat my pain due to fears of reprimand.
(1) #1 Deficiencies within state and/or federal laws regarding adequate treatment of pain.
30. The diagnosis I have been given by my health care provider is: (many varied responses - list compiled later)
If diagnosis was tumor: (0) malignant (cancer) (0) nonmalignant.

Barbara Afford
Kimberly Crane, RN
Virginia Goff
Leslie Reimer
Dee Krueger
Ann Wilson
Judy Cooper
Janetio Aldrete, MD
Val Aldrete, DDS
John Mahoney
Nancy Rice
Mara Marty
Betsy Dow

403 Locksley Ln
200 N. Calhoun
Consumer Advocate
Consumer Advocate
Consumer Advocate
Provider/Insurer
Provider/Insurer
Provider/Insurer
Provider/Insurer
Other
Other
Other
Other

Tallahassee, FL 32312
Tallahassee, FL
Tallahassee, FL
Tallahassee, FL
Gulf Breeze, FL
Panama City, FL
Tallahassee, FL
Chipley, FL
Chipley, FL
West Palm Beach, FL
Tallahassee, FL
Tallahassee, FL

YES
YES

RESPONSES TO STATISTICAL INFORMATION (RESPONSES OPTIONAL): (13)

31. Age: (0) Under 20 (3) 20 to 40 (9) Between 40 and 60 (1) 60 to 75 (0) Over 75
 32. Gender: (4) Male (9) Female
 33. Race: (check only one) (12) White (0) Black (1) Hispanic (0) Asian or Pacific Islander
 (0) American Indian or Alaskan Native (0) Other (specify) _____

TALLAHASSEE FORUM PERSONS IN ATTENDANCE

COMMISSION MEMBERS	AHCA STAFF	LHC MEMBERS
Allen Grossman, Esq.	Jeff Gregg	David Carter
Judy Harris, MS, RN	David Elkins	Danny Myers
Joe Johnson, DC	Sue St. Clair	
Paul Lambert, Esq.	Robbie Tootle	
David Mackey, MD		
Hubert Rosomoff, MD		
Renee Steele-Rosomoff, MS, RN		

PARTICIPANTS

Name	Description	Address	Testimony?
George Lederhaas, MD	Memiors Children's Clinic	Jacksonville, FL 32207	YES
Ann Wilson, RN	Bay Medical Center Hospice	Panama City, FL 32401	YES
Kurt A. Krueger, MD	4412 N. Davis Highway	Pensacola, FL 32504	YES
Joseph E. Alexander, RNC	7750 Fitch Ave.	Pensacola, FL 32514	YES
Dr. Mark Magenheim	Hospice of SW Fla	Sarasota, FL	YES
Robbie Laster	Rt. 5 Box 322	Chipley, FL 32428	YES
Mary Hardison	3125 Briarwood Dr.	Tallahassee, FL 32312	YES
Vivian Madison, LMT	2790 N. Military Trail #7	WPB, FL 33409	YES
J.A. Aldrete, MD	NW Fla. Community Hospital	Chipley, FL	YES
Cindy Sumner	2958 Bayshore Dr.	Tallahassee, FL 32308	YES
Dianne Tomlin, EMT	Provider/Insurer	Chipley, FL	YES
Joan Varner, RN	2626 Capital Medical Blvd	Tallahassee, FL	YES
Valentina Aldrete, DDS	CEO, CFO Pain and Spine Institute	Chipley, FL	YES
Barbara Alford	403 Locksley Ln	Tallahassee, FL 32312	YES
Kimberly Crane, RN	800 N. Calhoun	Tallahassee, FL	YES
Virginia Goff	Consumer Advocate	Tallahassee, FL	
Leslie Reimer	Consumer Advocate	Tallahassee, FL	
Dee Krueger	Consumer Advocate	Gulf Breeze, FL	
Ann Wilson	Provider/Insurer	Panama City, FL	
Judy Cooper	Provider/Insurer	Tallahassee, FL	
Janonio Aldrete, MD	Provider/Insurer	Chipley, FL	
Val Aldrete, DDS	Provider/Insurer	Chipley, FL	
John Mahoney	Other	West Palm Beach, FL	
Nancy Rice	Other	Tallahassee, FL	
Mara Merly	Other	Tallahassee, FL	
Betty Dear	Other		

REPORT: PAIN MANAGEMENT FORUM

Orlando, Florida

May 18, 1995

The second of three public forums sponsored by the Pain Management Commission was held in Orlando, Florida on May 18, 1995 at the Orange County Health and Human Services Building. Dr. Alvin Smith, Chairperson of the Pain Management Commission, served as moderator of the forum. Dr. Smith, nine (9) other commissioners and Dr. James Howell, Director, Division of Health Policy and Cost Control, Agency for Health Care Administration (AHCA), served as panel members. Assisting with the meeting were staff members the Agency for Health Care Administration and Local Health Council.

The purpose of the forum was to receive testimony from health care providers, pain sufferers and other interested parties related to pain management. The Pain Management Commission strongly believes that input from these groups is an important first step in the process of appropriately assessing the status of pain management in Florida and formalizing policy and recommendations to the Florida Legislature.

PUBLIC TESTIMONY

Fourteen (14) of the 34 individuals attending the forum presented oral testimony. Most of the speakers were from the medical community, primarily physicians, a number of whom also suffered from chronic pain. Other speakers represented chiropractic, massage therapy, health psychology, health education and hospice. Testimonies tended to focus on three general areas: (1) health practitioners that the speakers believed should be recognized and included in any formal recommendations relevant to pain management, (2) special types of pain that speakers thought should be recognized, and (3) issues the speakers believed should be addressed by the Commission.

Recommendation # 1: Health practitioners to include in pain management strategies

- Massage Therapists (and other therapists)
- Chiropractors
- Osteopathic Physicians

Recommendation # 2: Special types of pain to be addressed by the Commission

- Pediatric pain
- Labor pain

Recommendation # 3: Issues to be addressed by the Commission

- **Guidelines for Pain Management.** Many supported the concept of guidelines. However, there did not appear to be universal agreement on the types of guidelines that would best serve the purposes of health practitioners in the area of pain management. Such issues as the degree of specificity of the guidelines and the involvement of government seemed to be especially controversial.
- **Narcotics.** A number of physicians expressed concerns about the current laws monitoring physicians' prescriptions for their chronic pain patients. There was general agreement that a number of alternatives to narcotics are available for chronic pain, but there are a few patients for whom nothing else can be done to relieve their pain. The issues involve both federal and state guidelines for prescriptions for certain types of patients, including those covered by Medicare and Medicaid. There was general agreement that physicians do not have as many problems prescribing narcotics for terminally ill cancer patients.
- **Reimbursement.** This seems to be a major issue among most health care providers. Although the subjects varied, reimbursement problems emerged in many of the testimonies. Again, federal and state reimbursement guidelines are involved. Reimbursement in pain management centers and nursing homes is especially troublesome. Problems involve private insurers, including fee-for-service and managed care, as well as Medicare, Medicaid and Workers' Compensation.
- **Regulation of Pain Management Centers.** Thoughts were expressed that pain management centers should be recognized and come under some type of regulation and/or accreditation. Apparently, the only existing accreditation currently available to these centers is through other accrediting organizations, such as the Commission on Accreditation of Rehabilitation Facilities (CARF) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO). Accreditation would only apply to those centers with facilities and programs specific to these organizations. Testimony and comments by commission members revealed wide differences among pain management centers. It was believed that there should be common definitions of terms, such as "multidisciplinary" and some system for determining the types of services existing (or that should exist) in the various centers. Some physicians noted that they had no idea which centers, if any, might meet the needs of their patients.
- **Education.** A number of areas requiring education were identified. Patients need information regarding the alternatives available to them for pain management, including the use of various drugs. They also should have an understanding of their personal responsibilities regarding control of their pain, including control of their medications. Physicians should be trained to recognize and deal appropriately with their patients experiencing severe pain, both acute and chronic. Some suggested that the current requirement for AIDS education with renewal of licenses be altered to a rotation program that would include other special areas, such as pain management.
- **Outcomes Data.** Testimony was presented to reflect a need for comprehensive follow-up data to determine the effectiveness of various pain management techniques. Apparently some facilities involved in pain management do almost no follow-up data collection, while others have elaborate systems. Although a number of studies have been conducted in the various areas of pain management, no major statewide computerized base of pain management data appears to exist.

Development and implementation of a statewide system or comparable system would be valuable to research and expansion of the knowledge base for the area of pain management.

- 17. * **Grants Funds.** It was suggested that the Commission explore various funding sources, especially grants, to finance potentially costly activities, such as the development of a pain management data base and education of patients and health care providers.
- 18. * **Patient Lifestyle.** Suggestion was made that to help meet the needs of patients in pain a variety of factors should be explored, among them whether or not the patient smoked or was on birth control pills.
- 19. * **Certification of Pain Specialists.** Note was made that a physician prescribing drugs for chronic pain should have special training and be certified as a "pain specialist." This idea was not supported by those that prefer to have less governmental regulation.

21. Type of facility in which you provide health care (check all that apply)	22. How often do you prescribe pain medication to your patients?									
	(1) Never	(2) Rarely	(3) Sometimes	(4) Often	(5) Very Often	(6) Always	(7) Don't Know	(8) Refuse to Answer	(9) Other	(10) Total
Hospital	1	2	3	4	5	6	7	8	9	10
Outpatient clinic	1	2	3	4	5	6	7	8	9	10
Pain management center	1	2	3	4	5	6	7	8	9	10
Rehabilitation center	1	2	3	4	5	6	7	8	9	10
Other	1	2	3	4	5	6	7	8	9	10

* Should have read "Osteopathic Physician"

Summary of Survey Results Orlando Forum

QUESTIONS		# RESPONSES					WT.	
	SCALE:	1	2	3	4	5	Avg.	Rank
1.	All patients have a right to adequate pain management.	0	0	0	4	22	4.85	1
2.	There is a need for specialized centers for the treatment of pain.	0	1	5	9	11	4.15	8
3.	There is a need for specialists in the treatment of pain.	0	0	2	11	13	4.42	4
4.	Patients and caregivers should be actively involved in deciding the course of a pain management program.	0	0	0	5	21	4.81	2
5.	Health professionals administering pain medications should properly advise patients and caregivers of potential side effects of these medications.	0	0	0	6	20	4.77	3
6.	Licensed health care professionals should monitor pain management programs in the school settings.	1	0	9	8	8	3.85	9t
7.	Nurse practitioners should be allowed to prescribe controlled substances.	8	6	7	3	2	2.42	14
8.	People in pain should receive effective treatment regardless of whether they have a dependency drug problem.	0	0	1	14	11	4.38	5
9.	Drug addicts should be treated differently for pain.	4	4	4	11	3	3.19	13
10.	Health care providers who treat pain should administer pain assessment questionnaires to their patients.	1	0	2	10	13	4.31	6
11.	Government should be involved in prescribing pain medications.	12	9	2	1	2	1.92	15
12.	Government should disseminate accurate information from federal statutes regarding intractable pain.	0	4	5	9	8	3.81	11t
13.	Government should clarify state laws on intractable pain.	0	1	8	11	6	3.85	9t
14.	Government should protect health providers who treat intractable pain.	1	0	3	10	12	4.23	7
15.	Physicians fear prosecution as a result of prescribing narcotics for patients in pain.	0	2	7	11	6	3.81	11t

RESPONSES: ARE YOU A HEALTH CARE PROVIDER? YES (23) NO (3)

16. Do you provide pain treatment yourself?
(17) YES (4) NO (check all that apply) (13) ACUTE (14) CHRONIC (10) CANCER
17. The percentage of your patients requiring pain treatment is: (check only one)
(1) ZERO (1) Under 25% (1) 25% to 50% (2) Between 50% and 75% (10) 75% to 100% (2) All PM patients.
18. Have you interrupted or terminated pain treatment for a reason other than the patient no longer needed pain relief?
(11) YES (6) NO (2) NA If YES, specify reason: treatment ineffective, insurance problems, doctor wouldn't prescribe, nursing home not avail.
19. Do you fear prosecution as a result of prescribing narcotics for patients in pain.? (check only one)
(3) YES (6) NO (9) NA
20. PROFESSIONAL INFORMATION: (check and complete as applicable)
(6) Medical Doctor-specialty: (GP, FP, Neonatology, Anesth., PMR, Int. Med.) (4) Chiropractor (0) Podiatrist (0) Osteopath³
(0) Dentist (0) Pharmacist (2) Psychologist (1) Therapist-specialty: (PT)
(8) Nurse-specialty: (Hospice, Pain Mgt., Neuro., Ortho.) (0) Nurse Practitioner-specialty:

(0) Alternative specialist (type) _____ (1) Other (specify): (Counselor)
21. TYPE OF FACILITY IN WHICH YOU PROVIDE HEALTH CARE: (check as applicable)
(9) Office (4) Pain treatment facility (6) Hospice (1) Home health
Hospital: (8) inpatient (6) outpatient Ambulatory: (2) care center (1) outpatient surgery center
Rehabilitation facility: (4) inpatient (3) outpatient (3) Other (specify): (Pain program) .

Kathleen Allgood, RN			
Elaine Phillips			
William M. Silverman, DO	Family physician/FORAF/SACFP	Orlando	YES
James Drake	DLES/ODD	Orlando	
Jeanne McCarthy, MD	Physician	St. Petersburg	YES
Delphine R. Ballard		St. Anthony's, St. Petersburg	
Joy Gorzarian		St. Anthony's, St. Petersburg	
Peter J. Dunn		St. Anthony's, St. Petersburg	
Cindy Lashner		Columbia Park, Orlando	
Patty Medard, RN		Columbia Park, Orlando	
C. G.		Orlando	
Sandra Sander		Hospice of the FL Suncoast, Largo	YES

³ Should have read "Osteopathic Physician"

RESPONSES: DO YOU SUFFER FROM PAIN? YES (8) NO (18)

22. I suffer from pain: (0) no pain problem (1) rarely (3) occasionally (3) routinely (2) frequently
23. The pain that bothers me is located: (2) head (4) neck (2) upper back (1) lower back (1) arms (1) legs (0) knees (0) buttocks (3) other (hands, shoulders, abdomen).
24. The pain is : (0) acute (7) chronic (4) dull (7) aching (2) burning (2) sharp (2) numbing (1) mild (5) moderate (2) severe (1) incapacitating
25. My pain interferes with: (4) ability to sleep (5) ability to work (2) driving (3) activities of daily living (5) ability to enjoy leisure hours (2) ability to care for children/family (1) other
26. The type of medication(s) I have received for pain: (check all that apply)
(4) narcotics (3) anti-inflammatory (2) muscle relaxants (4) over-the-counter (Tylenol)
27. The type of treatment(s) I have received for pain: (check all that apply)
(2) physical therapy (1) counseling (2) biofeedback (2) visual imagery (2) massage therapy
(1) pain treatment facility (6) other (diet, exercise, stimulators, morphine pump, chiropractor, surgery, Paxil)
28. My assessment of the treatment(s) I have received for pain (check all that apply): (5) successful (1) unsuccessful (0) exceptional (1) adequate (2) disappointing (0) sensitive (0) insensitive
Do you consider your treatment inadequate? YES - Go to ITEM 29 NO - Skip to ITEM 30.
29. I attribute any inadequate treatment(s) or poor management of my pain to: (RANK your responses (1 to 5) with 1 representing your MOST important reason and 5 representing your LEAST important reason.)
_____ Insensitivity or lack of concern for my pain by my health care provider(s).
_____ Lack of knowledge of resources available to receive proper treatment for pain.
_____ Lack of appropriate health care providers/facilities to properly treat my pain in my community.
_____ Reluctance of my physician to prescribe adequate drugs to treat my pain due to fears of reprimand.
_____ Deficiencies within state and/or federal laws regarding adequate treatment of pain.
30. The diagnosis I have been given by my health care provider is: (bowel obstruction from adhesions, myofascial pain syndrome, sarcoma of the knee, osteoarthritis, migraine.)
If diagnosis was tumor: (1) malignant (cancer) (0) nonmalignant.

RESPONSES TO STATISTICAL INFORMATION (RESPONSES OPTIONAL): (25)

31. Age: (0) Under 20 (7) 20 to 40 (17) Between 40 and 60 (1) 60 to 75 (0) Over 75
32. Gender: (12) Male (13) Female
33. Race: (check only one) (25) White (0) Black (0) Hispanic (0) Asian or Pacific Islander
(0) American Indian or Alaskan Native (0) Other (specify)

ORLANDO FORUM PERSONS IN ATTENDANCE

COMMISSION MEMBERS

Willa Fuller, RN
Robert Guskiewicz, MD
Joe Johnson, DC
S. H. Kori, MD
Lori Ladd, RN
Paul Lambert, Esq
Steven Pyles, MD
Hubert Rosomoff, MD
Renee Steele Rosomoff, MS, RN
Alvin Smith, MD

AHCA STAFF

James Howell, MD
David Elkins
Robbie Tootle

LHC MEMBERS

Camilla Glenn
Susan Shewmaker
James Winslow

PARTICIPANTS

Name	Description	Address	Testimony?
David McGrew, MD	Academy of Hospice Physicians	Hernando Pasco Hospice, Spring Hill	YES
James Antos, DC	Chiropractor	Daytona Beach	YES
Wolfgang R. Munstea, DC	Chiropractor	Daytona Beach	
James Nash	Chronic pain sufferer	Lake Mary	
Rhea (Ray) Forman, PhD	Health Psychologist/Pain Mgt. Specialist	Health South Sea Pines Rehab Hospital, Melbourne	YES
Debbie Stiles		Atlantis	
Kathleen Allgeier, RN	Nurse	Palm Beach Pain Mgt, Atlantis	
Elaine Phillips		Orlando	
Ruth Angus, RN	Nurse	Good Shepherd Hospice, Auburndale	
Debra Powell	Abbott Labs		
Ginger Fauns		Hospice Central FL, Maitland	
Teresa Elwood		Hospice Central FL, Maitland	
Ted Carrick, DC, PhD	Professor		YES
Mark Anderson		Orlando	
Richard Turk		Halifax Hospital, Daytona Beach	
S. Hull		Maitland	YES
William M. Silverman, DO	Family physician/FOMA/FSACFP		
James Drake	DLES/ODD	Orlando	
Jeane McCarthy, MD	Physician	St. Petersburg	YES
Delphine P. Ballard		St. Anthony's, St. Petersburg	
Joy Gorzeman		St. Anthony's, St. Petersburg	
Peter J. Burns		St. Anthony's, St. Petersburg	
Cindy Leistner		Columbia Park, Orlando	
Patty Meifert, RN		Columbia Park, Orlando	
C. G.		Orlando	
Sandra Sunter		Hospice of the FL Suncoast, Largo	YES

PARTICIPANTS continued

Name	Description	Address	Testimony?
George M. Saviello, MD	Anesthesiologist/Obstetric	USF College of Medicine, Tampa	YES
Mary K. Johnson, RN	Nurse	Orlando	YES
Janet DuCharme		Winter Haven	
June Leland, MD	Physician	Hospice of Central FL, Maitland	YES
Michael Creamer, DO		Orlando	YES
Camilla Glenn, BS,MS,LMT	Massage Therapist	Maitland	YES
Mark Williams, PhD		Orlando	
David P. Kalin, MD, MPH	Physician	Largo	YES
Douglas Conigliaro, MD	FL Society of Anesthesiologists	Winter Park	YES

REPORT: PAIN MANAGEMENT FORUM

Miami, Florida

June 8, 1995

The third public forum sponsored by the Pain Management Commission was held in Miami, Florida on June 8, 1995 at the James Knight Center. Dr. Hubert Rosomoff, Vice Chairman, served as moderator of the forum. Dr. Rosomoff and five (5) other commissioners served as panel members. Assisting with the meeting were staff of the Agency for Health Care Administration (AHCA) and Local Health Council.

The purpose of the forum was to receive testimony from health care providers, pain sufferers and other interested parties related to pain management. The Pain Management Commission strongly believe that input from these groups is an important first step in the process of appropriately assessing the status of pain management in Florida and formalizing policy and recommendations to the Florida Legislature.

PUBLIC TESTIMONY

Forty-eight (48) of the 91 individuals attending the forum presented oral testimony. Of these 48 speakers, 26 (54.2%) were health care providers and the remaining 22 (45.8%) were pain sufferers. Testimonies tended to focus on three general issues: (1) use of narcotics to treat pain, (2) third party reimbursement for pain management services, and (3) education of professionals and the public. A summary of the testimonies is presented below.

USE OF NARCOTICS TO TREAT PAIN

Description of the Problem. Physicians are very reluctant to prescribe narcotics to treat pain. Pain sufferers and physicians stated there was a perceived fear that physicians will fall under scrutiny from the Drug Enforcement Administration or other enforcement entities. Cases were reported in which insurance companies rescinded doctors' prescription privileges due to what insurance companies described as the inappropriate use of narcotics.

Recommended Solutions:

- ✱ The government, in coordination with the American Pain Society, should create guidelines that recognize the need for narcotics use in the management of pain. These guidelines, however, must incorporate strict protocols to avoid abuse.
- ✱ The mere act of prescribing narcotics should not be a reason for insurance companies to rescind a physician's right to treat his/her patient in the manner he/she deems appropriate. Before these types of actions are undertaken, insurance representatives should familiarize themselves with the case, rather than assuming that narcotics are not medically necessary.

THIRD PARTY REIMBURSEMENT FOR PAIN MANAGEMENT SERVICES

Description of the Problem. Consumers and providers noted there is no uniformity among insurance companies for reimbursement of pain management services. According to testimony, many insurance companies, as well as Medicare and Worker Compensation (WC), customarily deny reimbursement for this type of care. Several speakers stated problems with the WC system, stating they were belittled and were made to feel that their pain was not something that required treatment. Through the testimony given, it appears the health care system is biased in favor of surgery for the treatment of pain. When the client continues to experience pain, however, the system becomes reluctant to reimburse for medication, equipment, or psycho-social services that improve the client's quality of life. In effect, the health care system focuses on acute care treatment, not the long term, chronic care needs of patients.

Recommended Solutions:

- Insurance companies must recognize the necessity of pain management, and they should reimburse providers and/or consumers for these services.
- There should be greater recognition of the long term needs of the chronic pain patient.

EDUCATION OF PROFESSIONALS AND THE PUBLIC

Description of the problem. Several health care professionals noted that pain management is absent from most medical and nursing curricula in universities throughout the state. Consequently, once these students enter their professions and are confronted by a patient suffering from pain, they do not know how to best care for the patient. This is especially true in the area of prescribing narcotics for pain, where lack of education, coupled with fear, is causing unnecessary suffering on the part of many patients.

Recommended solutions:

- Include courses on pain and pain management in university curricula.
- Require practitioners to continue their education in pain management, in the same way that it is required for HIV/AIDS.
- Providers, insurance company personnel, government entities, and the public must be taught the difference between narcotics as addictive drugs, and narcotics as useful adjuncts in a multidisciplinary approach to pain management.

SUMMARY OF SURVEY RESULTS

Miami Forum

QUESTIONS		# RESPONSES					WT.	
	SCALE:	1	2	3	4	5	Avg.	Rank
1.	All patients have a right to adequate pain management.	0	0	1	16	72	4.80	2
2.	There is a need for specialized centers for the treatment of pain.	1	2	2	14	70	4.69	5
3.	There is a need for specialists in the treatment of pain.	1	1	0	13	74	4.78	3
4.	Patients and caregivers should be actively involved in deciding the course of a pain management program.	0	1	0	22	66	4.72	4
5.	Health professionals administering pain medications should properly advise patients and caregivers of potential side effects of these medications.	0	0	1	13	75	4.83	1
6.	Licensed health care professionals should monitor pain management programs in the school settings.	0	3	23	28	35	4.07	9
7.	Nurse practitioners should be allowed to prescribe controlled substances.	17	22	25	16	9	2.75	14
8.	People in pain should receive effective treatment regardless of whether they have a dependency drug problem.	2	5	6	32	44	4.25	7
9.	Drug addicts should be treated differently for pain.	10	25	15	30	9	3.03	13
10.	Health care providers who treat pain should administer pain assessment questionnaires to their patients.	1	1	9	41	37	4.26	6
11.	Government should be involved in prescribing pain medications.	39	29	13	5	3	1.92	15
12.	Government should disseminate accurate information from federal statutes regarding intractable pain.	4	8	23	33	21	3.66	12
13.	Government should clarify state laws on intractable pain.	2	3	19	31	34	4.03	10
14.	Government should protect health providers who treat intractable pain.	0	1	20	29	39	4.19	8
15.	Physicians fear prosecution as a result of prescribing narcotics for patients in pain.	0	10	29	22	28	3.76	11

RESPONSES: ARE YOU A HEALTH CARE PROVIDER? YES (43) NO (46)

16. Do you provide pain treatment yourself?
(36) YES (7) NO (check all that apply) (12) ACUTE (33) CHRONIC (6) CANCER
17. The percentage of your patients requiring pain treatment is: (check only one)
(2) ZERO (2) Under 25% (2) 25% to 50% (3) Between 50% and 75% (18) 75% to 100%
(13) All PM patients.
18. Have you interrupted or terminated pain treatment for a reason other than the patient no longer needed pain relief?
(20) YES (15) NO (8) NA If YES, specify reason: insurance problems, patient not cooperative, litigation, drug dependency.
19. Do you fear prosecution as a result of prescribing narcotics for patients in pain? (check only one)
(4) YES (12) NO (27) NA
20. Professional Information: (check and complete as applicable)
(8) Medical Doctor-specialty: (Anesthesiology, Family Practice, Phy. Med., Rehab) (1) Chiropractor (0) Podiatrist (0) Osteopath⁴
(0) Dentist (0) Pharmacist (1) Psychologist (15) Therapist-specialty: (PT, OT, Psycho, Rehab., Ex Physiology)
(12) Nurse-specialty: (Pain Mgt., Rehab, Critical Care, Oncology) (0) Nurse Practitioner-specialty: _____
(3) Alternative specialist (type) (Acupuncture, Ergonomics) (4) Other (specify): (Administration, Rehab Engineer)
21. Type of facility in which you provide health care: (check as applicable)
(1) Office (29) Pain treatment facility (2) Hospice (2) Home health
Hospital: (14) inpatient (15) outpatient Ambulatory: (0) care center (1) outpatient surgery center
Rehabilitation facility: (12) inpatient (15) outpatient (1) Other (specify): ().

⁴ Should have read "Osteopathic Physician"

RESPONSES: DO YOU SUFFER FROM PAIN? YES (45) NO (44)

22. I suffer from pain: (0) no pain problem (0) rarely (5) occasionally (6) routinely (34) frequently
23. The pain that bothers me is located: (9) head (22) neck (15) upper back (32) lower back (8) arms (20) legs (13) knees (14) buttocks (14) other (feet, hips, ankles, face, groin, hands, middle back, perineal area, shin).
24. The pain is: (14) acute (29) chronic (7) dull (22) aching (20) burning (20) sharp (14) numbing (4) mild (16) moderate (19) severe (12) incapacitating
25. My pain interferes with: (31) ability to sleep (27) ability to work (16) driving (36) activities of daily living
(31) ability to enjoy leisure hours (10) ability to care for children/family (6) other (everything, sexual activity, portrait painting)
26. The type of medication(s) I have received for pain: (check all that apply)
(23) narcotics (26) anti-inflammatory (22) muscle relaxants (18) over-the-counter (Tylenol, Aspirin, Advil, Motrin, Caltrate, Excedrin)
27. The type of treatment(s) I have received for pain: (check all that apply)
(34) physical therapy (21) counseling (16) biofeedback (11) visual imagery (27) massage therapy
(20) pain treatment facility (9) other (TENS, chiro., surgery, dorsal coli stim., ice, moist heat, phy rehab, spinal block, support group)
28. My assessment of the treatment(s) I have received for pain (check all that apply): (12) successful (22) unsuccessful (4) exceptional (9) adequate (22) disappointing (2) sensitive (6) insensitive
Do you consider your treatment inadequate? YES - Go to item 29 NO - Skip to item 30.
29. I attribute any inadequate treatment(s) or poor management of my pain to: (rank your responses (1 to 5) with 1 representing your most important reason and 5 representing your least important reason.)
2 Insensitivity or lack of concern for my pain by my health care provider(s).
1 Lack of knowledge of resources available to receive proper treatment for pain.
5 Lack of appropriate health care providers/facilities to properly treat my pain in my community.
3 Reluctance of my physician to prescribe adequate drugs to treat my pain due to fears of reprimand.
4 Deficiencies within state and/or federal laws regarding adequate treatment of pain.
30. If diagnosis was tumor: (0) malignant (cancer) (2) nonmalignant.

RESPONSES TO STATISTICAL INFORMATION (RESPONSES OPTIONAL): ()

31. Age: (0) Under 20 (26) 20 to 40 (37) Between 40 and 60 (13) 60 to 75 (5) Over 75
32. Gender: (34) Male (43) Female
33. Race: (check only one) (65) White (4) Black (7) Hispanic (0) Asian or Pacific Islander
(1) American Indian or Alaskan Native (1) Other (specify)

MIAMI FORUM PERSONS IN ATTENDANCE

COMMISSION MEMBERS

David Fishbain, MD
Willa Fuller, RN
Paul Lambert, Esq
Hubert Rosomoff, MD
Renee Steele Rosomoff, MS, RN
Joel Stein, DO

AHCA STAFF

Linda Macdonald
Sue St. Clair

LHC STAFF

Sonja R. Albury
Silvia Blanco
Wendy Hucksell
Robert Harris
Richard Rodriguez
Elizabeth Rugg

PARTICIPANTS

Name	Description	Address	Testimony?
Tammy Butler, RN	Palm Beach Pain Management	Atlantis, FL	
Andrew Weiss, MD	Palm Beach Pain Management	Atlantis, FL	
Sally Rech	PSO Support Group	Miami	YES
Margia Beeman, MSW		Coconut Creek, FL	
Peggy Rogers	Miami Herald	Miami	
Mark H. Spencer	UTS	Miami	
R. Duff Masterson	HHSPC	Miami Springs, FL	
Alex Choto	Palmetto General Hospital	Davie, FL	
Dorolly Quinlan		Miami	
Alan Sadowsky	St. Mary's Rehab.	Miami	YES
Richard Compton	UMCPRC	Miami Beach	
Dorothy Quinlan			
Debbie Parnell	Abbott Labs	Miami	
Rosalee McCurdy		Miami	
Barrs Kehzhammer	Uitas Healthcare Group	Miami	
Sherry Sanabria		Miami	
Wanda Latish	Mercy Hospital	Miami	
George Bonis	Neuro Rehab	Tamarac	
Molly Levy	CPRC	Miami Beach	
Ruth Zucherman	CPRC	Lds. Hill	
Charlie Bean	CPRC	Miami	
Suzanne Johnson	UMCPRC	Miami	YES
Sally S. Rech	RSDS/ State of FL	Miami	
Yoka Kovacs		SM, CA	
Patricia E. Bathgale	CPRC	Miami	
Kathleen L. O'Neil		Miami	
R. Kever		Miami	
Alma R. Abdel, OT	CPRC	Miami	YES
Elsayed Abdel		Miami	YES
Javier Ruiz, MD	Mercy Hospital	Coconut Grove, FL	
Aduana Fajardo	Mercy Hospital	North Miami Beach	
Ross Rubens		North Miami Beach	
Valorie Noonan		Miami	
Usa Marinari		Miami	
Maria Duque	Dept. of Labor/ODD	Miami	
Robert Keren		Miami Beach	
Morton Egetz, MD	Catholic Hospice	Miami	

PARTICIPANTS continued

Name	Description	Address	Testimony?
Sam Oprouseck, Jr.		Port St. Lucie, FL	
Arthur Reid	UMCPRC	Miami Beach	
Ellen Loiacond		Miami Beach	
Louse Kraus		Bay Harbor, FL	
Gloria Martinez	UMCPRC	Miami	
Brian Craythorie	UM Dept. of Anesthesia	Key Largo, FL	
Tarek Khalil	UM graduate school	Coconut Grove, FL	YES
Robert M. McKelvey		Miami	
Angetique Hart	JMH/CPRC	Miami Springs, FL	
Brandly Cole	UMCPRC	Miami Beach	
Maria Ayala		Miami	
Marcia Locurto	NMC Homecare	Deerfield, FL	
Jay Hancock	Deering Pain Management Ctr	Miami	
Heather Famiglietti		Sunrise, FL	
Mark Levin		Miami	
Aldon Williams	Anesthesia/CPRC	Miramar, FL	
D.J. Patin, MD	UM Anesthesia	Miami	
Elizabeth Rockowitz	UM Anesthesia	Miami	
Ross B. Gampel	Deering Pain Management Ctr	Miami	
Miriam B. Jimenez		Miami	
Pedro Rodriquez		Hialeah, FL	
Paul Lanier		Florida City, FL	
Wilhelmena Burke		Miami	
Albert Ray, MD		Miami	YES
Robert L. Parent		Miami	
Laurie Parent		Miami	
Marilyn Vmanash	Deering Pain Management Ctr	Miami	
Elaine Marks	Deering Pain Management Ctr	Miami	
Rhonwyn Ullmann	Deering Pain Management Ctr	Miami	
Steve Ullmann	University of Miami	Coral Gables, FL	
Cynthia Bearden McAdory	First-Med Primary Care	Miami	
Gary Burkke		Miami	
Adriene Barmunn	University of Miami	Miami	
Richard S. Cotler		Hollywood, FL	
Alan Saltzman, MD	University of Miami	Miami Beach	
Alicia Belinotti	University of Miami	Miami Beach	
A. Liegsm.			
Larry M. Herman	Deering Pain Management Ctr	Miami	
Sandy Herman	Deering Pain Management Ctr	Miami	
Raul Mariana	Deering Pain Management Ctr	Miami	
Shane Meeleh	Deering Pain Management Ctr	Miami	
William Millett	Columbia Healthcare	Nashville, TN	
Susan Martinson	UMCPRC	Miami	
James Milne		Ft. Lauderdale	
Mary DeSimove	UMCPRC	Hollywood, FL	
Julie Dominguez	UMCPRC	Miami Beach	
Adam Frogel		Miami	
Mark A. LaPorta, MD	Physician		
Pat Collins	FCPI	Miami	
Felicia Dickman		Ft. Lauderdale	
James B. Dwyer		Boynton Beach, FL	YES



FOR MORE INFORMATION, CONTACT THE

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